RULES
OF
PROCEDURE

Revised May 2004

NEBRASKA WORKERS'
COMPENSATION COURT

STATE CAPITOL BUILDING
LINCOLN, NEBRASKA 68509-8908

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ADDENDA

RULE 1

OFFICE OF THE COURT

The office of the Nebraska Workers' Compensation Court shall be deemed to be in the State Capitol Building, Lincoln, Nebraska.

Hearings or review hearings in compensation cases may be held at any other place within the State as provided by statute, but no such other place shall be deemed to be an office or branch office of the court.

Sections 48-177, 48-186, R.R.S. 1998, and 48-179, R.S. Supp., 2002.
Dolner vs. Peter Kiewit & Sons Co., 143 Neb. 384; 9 N.W. 2nd 483.
Effective date July 1, 1997.

RULE 2

FILINGS

No paper or pleading regarding a proceeding of the Nebraska Workers' Compensation Court shall be deemed to be filed with the court until the same has been received and recorded by the clerk of said court at the office of the court in Lincoln. Upon filing of a petition or initial pleading in a case that has not yet been assigned a docket number, such petition or pleading shall include the social security account number of the claimant together with the date and location of injury or alleged injury.

All instruments filed with or correspondence forwarded to the court shall be stamped or imprinted by the court with the date of receipt. Time limits prescribed by law or these rules shall be calculated from the date of filing as reflected by the receipt date recorded on the instrument or correspondence.

Sections 48-157, R.R.S. 1998, and 48-179, R.S. Supp., 2002.
Dolner vs. Peter Kiewit & Sons Co., 143 Neb. 384; 9 N.W. 2nd 483.
Effective date July 28, 1999.

RULE 3

PLEADINGS

A. All petitions must be filed in duplicate, one for the court files and one for the adverse party. No greater number need be filed, except when there is more than one adverse party, in which case a copy must be furnished for each such additional party. Whenever a motion or stipulation is filed, a proposed order shall accompany such motion or stipulation. All petitions, answers, motions, forms, proposed orders, other pleadings and filings shall be printed or typewritten in standard pica or elite type on 8½ by 11 inch paper of at least 16-pound substance. No reductions of print or type will be accepted. Double spacing is allowed but one and one-half spacing is encouraged, together with one-inch margins. Facsimile copies are acceptable as provided in the Nebraska Supreme Court Rules for the use of FAX machines in State Courts.

B. Every pleading subsequent to the petition, every written motion, every document relating to discovery or disclosure, and every written notice, appearance, designation of record on appeal, and similar document shall be served upon each of the parties by the initiating party. Except as provided in section C, such party shall file proof of service with the court. Service and proof of service shall be made in accordance with Rule 16,A,5.

1. Except as otherwise provided by law, any motion or similar filing in which a hearing is requested shall be in writing and filed with the Clerk not less than five days prior to hearing except by permission of the trial judge.
2. Counsel at the time of filing shall obtain a date for hearing from the judge to whom the case is assigned or the judge's secretary and file a notice of hearing with the filing. Unless approved by the judge, a hearing date must be obtained for each motion, even if motions in the same case are already scheduled.
3. Notice of hearing shall be mailed or personally delivered to opposing counsel or party, if unrepresented, three full days prior to hearing. The use of ordinary mail shall constitute sufficient compliance with this rule, except as may be otherwise specifically required by statute or rule of this court or the Supreme Court.
4. To avoid delays in the progression of a case, the court shall refuse to consider any and all motions, including motions to compel, unless

moving counsel, as part of the motion makes a showing that, after personal consultation with counsel for opposing party(ies) and reasonable efforts to resolve differences, counsel are unable to reach an accord. This showing shall recite, additionally, the date, time and place of such conference and the names of all participants. The term "counsel" shall include parties acting pro se.

C. Discovery materials that do not require action by the court shall not be filed with the court. All such materials, including notices of deposition, depositions, certificates of filing a deposition, interrogatories, answers and objections to interrogatories, requests for documents or to permit entry upon land and responses or objections to such requests, requests for admissions and responses or objections to such requests, subpoenas for depositions or other discovery and returns of service of subpoenas, and related notices shall be maintained by the parties. Discovery materials shall be filed with the court only when ordered by the court or when required by law.

D. Copies of all correspondence and any other instruments sent to the court shall be mailed by the party originating the correspondence to all other parties of record in the case.

E. Any pleading, instrument, correspondence or order submitted to the court or to any judge thereof shall bear the typed or printed name and the signature of the person who prepared the instrument or correspondence, the firm name if applicable, the complete address including the zip code, the telephone number, including the area code and the court's docket and page number if one has been assigned to the claim. If the instrument or correspondence has been prepared by legal counsel, the counsel's Nebraska Bar Association number shall also be listed.

F. The signature of an attorney or party constitutes the following:

1. a certification by him or her that he or she has read the paper;
2. that it is not interposed for any improper purpose such as to harass or to cause unnecessary delay or needless increase in the cost of litigation;
3. that to the best of his or her knowledge, information and belief formed after reasonable inquiry, it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification or reversal of existing law; and

4. that any allegations or denials of facts have evidentiary support or, if specifically so identified, are likely to have evidentiary support after a reasonable opportunity for further investigation or discovery.

Section 48-163, R.S. Supp., 2002.
Effective date December 17, 2002.

RULE 4

DISCOVERY

Discovery in the Workers' Compensation Court shall be pursuant to the Nebraska Discovery Rules For All Civil Cases promulgated by the Nebraska Supreme Court. A pretrial conference may be scheduled and a pretrial order may be entered. If a pretrial order is entered, it will control the subsequent proceedings unless modified at trial to prevent manifest injustice.

Sections 48-164, R.R.S. 1998, and 48-163, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 5

DISCOVERY

Repealed effective July 1, 1997.

RULE 6

PRETRIAL CONFERENCES

A. The court may in its discretion direct the attorneys for the parties and any unrepresented parties to appear before it for a conference or conferences before trial for such purposes as:

1. expediting the disposition of the action;
2. establishing early and continuing control so that the case will not be protracted because of lack of management;
3. discouraging wasteful pretrial activities;

4. improving the quality of the trial through more thorough preparation, and;
5. facilitating the settlement of the case.

A pretrial order may be entered, and if entered it will control the subsequent proceedings unless modified at trial to prevent manifest injustice.

B. Failure to appear at a conference, appearance at a conference substantially unprepared or failure to participate in good faith may result in any of the following sanctions:

1. an order entered by default;
2. assessment of expenses and fees (either against a party or the attorney individually); or
3. such other order as the court may deem just and appropriate.

C. The court may in its discretion schedule a pretrial mediation conference to be facilitated by a staff member of the court in accordance with Rule 48, for the purpose of facilitating settlement of the case.

Section 48-163, R.S. Supp., 2002.
Effective date December 24, 1997.

RULE 7

ALLOTTED TIME FOR TRIAL

Cases set for trial before one judge shall be set by the court for an allotted time period of one-half day unless at least 45 days prior to trial, the court is notified by a party or the parties that more or less time will be needed and the length of time that will be needed for trial of the case.

Section 48-163, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 8

CONTINUANCES

No continuance will be granted because of a conflict in another court unless the case in the other court is set prior to the setting in this court nor because of any

other conflict unless it predates the setting in this court and unless this court receives notification of such conflict immediately upon receipt of notice of hearing or review hearing.

No continuance will be granted because an attorney overlooked this court's notice of hearing or because the attorney's secretary failed to enter the notice on the attorney's calendar.

No continuance will be granted if a request for assignment of a vocational rehabilitation counselor pursuant to Rules 42 and 45, a request for informal dispute resolution pursuant to Rule 48, or a request for assignment of an independent medical examiner pursuant to Rule 63 is made less than 60 days prior to the date set for hearing.

A continuance, under any circumstances, may be granted if good cause is shown; however, no continuance shall be granted within two weeks of the date of hearing unless an emergency arises.

The fact that a request for continuance is a joint request will not change the foregoing restrictions.

Section 48-163, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 9

REPORTING OR RECORDING THE PROCEEDINGS

The employer or, if insured, the employer's insurance carrier shall furnish a court reporter to be present and report or, by adequate mechanical means, to record and, if necessary, transcribe proceedings of any hearing. The reporter's charges for attendance shall be paid initially to the reporter by the employer or, if insured, by the employer's insurance carrier. The reporter shall faithfully and accurately report or record the proceedings. If the State of Nebraska, Workers' Compensation Trust Fund, is the only defendant, it shall furnish and pay initially the reporter's charges.

Section 48-178, R.R.S. 1998.
Effective date December 19, 2000.

RULE 10

EVIDENCE

A. Medical and Vocational Rehabilitation. The Nebraska Workers' Compensation Court is not bound by the usual common law or statutory rules of evidence; and accordingly, with respect to medical evidence on hearings before a single judge of said court, written reports by a physician or surgeon duly signed by him, her or them and itemized bills may, at the discretion of the court, be received in evidence in lieu of or in addition to the personal testimony of such physician or surgeon; with respect to evidence produced by vocational rehabilitation experts, physical therapists, and psychologists on hearings before a single judge of said court, written reports by a vocational rehabilitation expert, physical therapist, or psychologist duly signed by him, her or them and itemized bills may, at the discretion of the court, be received in evidence in lieu of or in addition to the personal testimony of such vocational rehabilitation expert, physical therapist, or psychologist. A sworn statement or deposition transcribed by a person authorized to take depositions is a signed, written report for purposes of this rule.

A signed narrative report by a physician or surgeon, vocational rehabilitation expert, or psychologist setting forth the history, diagnosis, findings and conclusions of the physician or surgeon, vocational rehabilitation expert, or psychologist and which is relevant to the case shall be considered evidence on which a reasonably prudent person is accustomed to rely in the conduct of serious affairs. The Nebraska Workers' Compensation Court recognizes that such narrative reports are used daily by the insurance industry, attorneys, physicians and surgeons and other practitioners, and by the court itself in decision making concerning injuries under the jurisdiction of the court.

Any party against whom the report may be used shall have the right, at the party's own initial expense, of cross examination of the physician or surgeon, vocational rehabilitation expert, or psychologist either by deposition or by arranging the appearance of the physician or surgeon, vocational rehabilitation expert, or psychologist at the hearing. Nothing in this rule shall prevent deposition or live testimony of the physician or surgeon, vocational rehabilitation expert, or psychologist. Unless exceptional cause is shown and extremely unusual circumstances exist, all evidence shall be submitted at the time of hearing.

If the original of a deposition is not in the possession of a party who intends to offer it in evidence at a hearing, that party shall give notice to the party in possession of it that the deposition will be needed at the hearing. Upon receiving such notice, the party in possession of the deposition shall either make it available to the party who intends to offer it or produce it at the hearing.

B. Motions for Summary Judgment or other Motions for Judgment on the Pleadings. With respect to hearings on motions for summary judgment or other motions for judgment on the pleadings under section 48-162.03, the proceedings shall be governed by Neb. Rev. Stat. §§ 25-1330 et seq.

Sections 48-162, 48-168, R.R.S. 1998, and 148-163, 48-179, R.S. Supp., 2002.
Effective date December 17, 2002.

RULE 11

DECISIONS

A. Reasoned Decisions. All parties are entitled to reasoned decisions which contain findings of fact and conclusions of law based upon the whole record which clearly and concisely state and explain the rationale for the decision so that all interested parties can determine why and how a particular result was reached. The judge shall specify the evidence upon which the judge relies. The decision shall provide the basis for a meaningful appellate review.

B. Official Version. The official version of any findings, order, award, or judgment of the court shall be the original, signed version which is on file with the Clerk of the Court.

Section 48-178, R.R.S. 1998.
Effective date December 17, 2002.

RULE 12

APPEALS

A. Appeals for a review to a three-judge panel may be taken by filing an original and three copies of an Application for Review within 14 days from the date the order appealed from was filed with the court as reflected by the date of the file stamp thereon. No party may file a Motion for New Trial, a Motion for Reconsideration or a Petition for Rehearing before the trial judge. The Application for Review shall include:

1. A specific statement of each conclusion of law and finding of fact urged as error. General allegations will not be accepted. The party or parties appealing to the three-judge panel will be bound by the allegations of error contained in the Application for Review and will be deemed to have waived all others; and
2. A brief statement of the relief sought.

B. Upon receipt of the material required by Rule 12,A, the clerk of the court shall thereupon docket the case designating the party or parties first having filed the Application for Review as appellant or appellants. All other parties shall be designated as appellees, and any attempt to appeal thereafter made by any party to the action shall be filed in the existing case, and not separately docketed.

C. Cross-Appeal. The proper filing of an appeal shall vest in an appellee the right to a cross-appeal against any other party to the appeal. The cross-appeal need only be asserted in the appellee's brief as provided by Rule 16,C,3.

D. Appeals for a review to the three-judge panel shall be strictly on the record made before the trial court. No new evidence shall be allowed.

E. Oral argument shall be limited to 10 minutes to each side unless the time is enlarged by leave of the court. Any party failing to appear when the appeal is called for oral argument shall be deemed as having waived the right to argue the case and the appeal shall be considered as being submitted on the record. If a basis of the appeal involves medical evidence, or other disputed questions of fact, 3 copies of the relevant document(s) shall be presented to the three-judge panel at the time of oral argument.

Sections 48-180, 48-182, R.R.S. 1998, and 48-163, 48-179, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 13

TRANSCRIPT OF PLEADINGS

A. How Ordered; Contents.

1. Upon filing the Application for Review the appellant shall file with the court a praecipe directing the clerk to prepare a transcript, which shall contain:
   a. such of the pleadings upon which the case was tried, as designated by the appellant;
   b. the petition, amended petition(s), answer, amended answer(s), the final order, award or judgment, sought to be reversed, vacated, or modified, and the court's decision; and
   c. copies of the Application for Review and request for transcript, and copies of the request for bill of exceptions and poverty affidavit if those documents were filed.
2. If the appellant is of the opinion that other parts of the record are necessary for the proper presentation of the errors assigned in this court, he or she shall, within 10 days, further direct the clerk to include in the transcript such additional parts of the record as he or she shall specify in the praecipe. The appellant shall limit his or her request for such additional material to only those portions of the record which are material to the assignments of error.
3. In filing a praecipe for transcript with the clerk of the court, the party making such praecipe shall identify by name such specific document which the party desires to have included in the transcript pursuant to this rule. The clerk of the court may not include without specific written request, a copy of any document not required under this rule. The clerk shall, upon request, certify that the record does not contain a described document.

B. Supplemental Transcript. After the original transcript of pleadings is filed in the office of the clerk, any party may, within ten days, without leave of court, request a supplemental transcript of pleadings containing matters omitted from the original transcript of pleadings and necessary to the proper presentation of the case in this court. The request shall be in writing, and in the same form as required of the appellant. After filing, no change in the original or supplemental transcript of pleadings shall be made, or papers added to or withdrawn from the transcript, without leave of court. All supplemental transcripts must be filed thirty days prior to the day the case is submitted to the court, unless leave

of court is obtained in advance to file later. Supplemental transcripts shall be submitted in the same form as transcripts.

C. Payment for Transcript. The party making the request shall pay the cost of the transcript or supplemental transcript of pleadings to the court within fourteen days after being billed by the court.

Section 48-182, R.R.S. 1998, and sections 48-163, 48-179, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 14

BILL OF EXCEPTIONS

A. How Ordered; Contents.

1. Appellant shall file a request to prepare a bill of exceptions in the office of the clerk of the court at the same time the Application for Review is filed. At the same time, appellant shall deliver a copy of the request to the court reporter.
2. The request shall specifically identify each portion of the evidence and exhibits offered at any hearing which the party appealing believes material to issues to be presented for review. The court reporter shall prepare only those portions specified in the request for preparation of the bill of exceptions. If the appellant intends to urge on appeal that a finding or conclusion is unsupported by the evidence or is contrary to the evidence, the bill of exceptions must include all evidence relevant to the finding or conclusion. The appellant shall serve a copy of the request upon the appellee.
3. If the appellee believes additional evidence should be included in the bill of exceptions, the appellee shall, within 10 days after service of the request for bill of exceptions filed by the appellant, file a supplemental request for preparation of bill of exceptions. The request shall be filed with the clerk of the court, and a copy shall be delivered simultaneously to the court reporter by appellee.
4. The bill of exceptions shall contain only matters of evidence or exhibits which are necessary for a determination of the issues on appeal.
5. Except in those cases where payment is to be made by a governmental agency, the State of Nebraska, or any political or governmental subdivi-

sion thereof, the court reporter shall advise appellant of the approximate cost of the bill of exceptions immediately after receipt of the request for preparation of the bill of exceptions. Appellant shall deposit the estimated cost with the reporter within 14 days after receipt of the estimate. The court reporter shall retain the deposit in a separate trust account until the bill of exceptions is filed with the clerk of the court. When the bill of exceptions is filed by the reporter, the reporter shall immediately refund any excess payment to the appellant. If additional compensation is due the reporter, appellant shall pay the additional amount within 10 days after receipt of a statement for the additional amount. A similar procedure shall be followed if an appellee requests a supplemental bill of exceptions, with the appellee being responsible for payments.

6. The party requesting the preparation of the bill of exceptions may, at any time before the bill of exceptions is completed by the court reporter, file with the clerk of the court and serve upon the court reporter a statement advising the court reporter that settlement has been reached. Upon receipt of such statement, the court reporter shall cease any further work upon the bill of exceptions. The court reporter shall be entitled to payment by the party ordering such bill of exceptions for the work performed up to the time that such notice was served upon the court reporter, and rules with regard to payment of the fees to the court reporter for the bill of exceptions, as otherwise provided herein, shall apply.

B. Preparation and Delivery by Reporter.

1. The bill of exceptions shall be filed with the clerk of the court as soon as possible. The bill of exceptions must be filed within two months unless an extension of time is approved by the court in accordance with these rules. Such preparation date is to commence from the date the Application for Review is filed with the clerk of the court. The clerk of the court shall serve a copy of the Application for Review on the reporter forthwith.
2. In each case appealed to the court, the reporter shall prepare an original of the bill of exceptions; the original, together with all documentary and other evidence, shall be filed with the clerk of the court. The reporter may retain the bill of exceptions until the deposit is made in compliance with Rule 14,A,5.
3. If the reporter is unable to prepare and certify a bill of exceptions, or if a bill of exceptions cannot be prepared and certified under provisions contained elsewhere in these rules, the bill of exceptions shall be prepared

under the direction and supervision of the trial judge and shall be certified by the judge and delivered to the clerk of the court.

4. Upon receipt of the bill of exceptions, the clerk of the court shall forthwith file it and notify all parties or their attorneys of record of the date of such filing. When filed with the clerk of the court, such bill of exceptions becomes the official bill of exceptions in the case and shall not be altered or marked in any fashion by any person.

C. Extension of Time for Preparation of Bill of Exceptions.

1. Where a bill of exceptions has been ordered according to law and these rules by the timely filing of a request, and the reporter is unable to prepare and file the bill of exceptions with the clerk of the court within the times fixed by this rule, the court may grant additional time for preparation of the bill of exceptions.
2. A request for additional time for preparation of the bill of exceptions may be made by any party to the action. The request shall be made by motion or by the stipulation of all parties to the action. The motion or stipulation must be accompanied by the original copy of the affidavit of the court reporter setting forth the following information:
   a. the work performed in court since the receipt of the request on which extension is being requested;
   b. the number of requests on hand on the date of receipt of the request on which extension is being requested;
   c. the estimated total pages comprising the bill of exceptions, together with the number of pages completed as of the date the extension is requested;
   d. any illnesses or family emergencies contributing to the need for the requested extension; and
   e. the method of preparing the bill of exceptions; e.g., prepared by the reporter, note-reader used, or dictated by the reporter and prepared by a typist.
3. A request for extension must be made not later than 7 days prior to the expiration of the time originally prescribed, or not later than 7 days prior to the expiration of an extension previously granted. A first extension will not be routinely granted.
4. Except for exceptional cause, no more than one 2-week extension of the time originally prescribed will be granted.

D. Amendments to the Bill of Exceptions. The parties in the case may amend the bill of exceptions by written agreement to be attached to the bill of exceptions at any time prior to the time the case is submitted to the court. Proposed amendments not agreed to by all the parties to the case shall be heard and decided by the court after such notice as the court shall direct. The order of the court thereon shall be attached to the bill of exceptions prior to the time the case is submitted to the court. Hearings with respect to proposed amendments to a bill of exceptions may be held at chambers anywhere in the state. If the judge shall have ceased to hold office, or shall be prevented by disability from holding the hearing, or shall be absent from the state, such proposed amendments shall be heard by the successor judge, or by another judge of this court.

E. Form of the Bill of Exceptions.

1. The bill of exceptions shall have an index, which shall be the first item in the first volume. The index shall show;
   a. each witness in the order called, and for whom called, and the initial page of the direct, cross, redirect, and recross examination,
   b. motions to dismiss or to instruct a verdict and any other motions of major import, and stipulations, together with the rulings of the court thereon, and the page or pages where made and ruled on, and
   c. all exhibits, with a description, and the initial page where marked, offered, ruled on, and found.
2. The certificate of the court reporter shall immediately follow the index in the first volume of the bill of exceptions.
3. The paper used in the bill of exceptions shall be 8½ by 11 inches and of suitable weight and quality to make the typing thereon easily legible. Twelve point (10-pitch pica) type shall be used. Each volume shall be bound on the left-hand side with either a wire or a plastic spiral. The pages, no matter how many volumes, shall be numbered consecutively, and no volume shall contain over 250 pages. If the record is of such size that it requires more than one volume, then all volumes shall be as nearly of equal size as possible. Each page of the bill of exceptions shall have line numbers in the left-hand margin from 1 to 25, inclusive, and the lines of typing shall be placed to correspond therewith. No margin line shall exceed ½ inch from the right-hand edge of the page. The full name of each witness and whether the examination is direct, cross, or further examination shall be stated at the top of each page of the witness' testimony. Each volume must be an original copy and must have a cover and back; the cover shall

be of flexible and the back of rigid material. Exhibits are to be marked in numerical order, irrespective of the party producing them and shall show the date on which they were marked. The same number shall not be given to more than one exhibit in any case. If the pages of a multipage exhibit are not otherwise numbered, the reporter shall number the pages in sequence and shall in all instances mark such an exhibit so as to indicate the number of pages it contains. Ordinarily, exhibits or papers contained in the bill of exceptions should be placed in the record immediately following where they are ruled on by the court. If exhibits are frequently referred to in the testimony, they should be inserted in the record in such a manner as to be easily removed; for instance, by placing them in an attached envelope. If the exhibits are of such character or so numerous that to insert them in any volume containing testimony would make the volume cumbersome and difficult to handle while reading, then such exhibits should be contained in a separate volume. If exhibits are of such character that they cannot be inserted in a bound volume, then they should separately accompany the record. Whether in separate volumes or separately accompanying the record, all exhibits should be properly identified as part of the record in the reporter's certificate. Except for documents, which term includes photographs and taped video and sound recordings, the bill of exceptions shall contain no item of physical evidence. The term "physical evidence" means any nondocumentary items as defined above and includes, but is not limited to, items such as weapons, contraband, wearing apparel, models, money, and body fluids. The party offering any nondocumentary item of physical evidence shall substitute therefor a photograph, not larger than 8½ by 11½ inches, which fairly and accurately depicts the item. If the party offering an item of nondocumentary evidence fails to provide a suitable substitute photograph, the court reporter shall cause one to be made at the offering party's expense. The court reporter shall in all instances preserve the nondocumentary item of physical evidence and shall make it available to the court upon request. The bill of exceptions shall be visually neat. No typing errors or corrections shall be unduly noticeable. All corrections and additions shall be on the same line as the rest of the typed line; no insertion is permitted in the space between two lines of type. Corrections shall not be written in.

F. Videotape Exhibits and Videotape Depositions. The standard videotape for the court shall be VHS. The court shall maintain videotape equipment capable of playback of VHS videotape. If any other videotape, e.g., Beta, is presented to the court as an exhibit or deposition which is not able to be played back on

VHS equipment, the party submitting the videotape shall provide at his or her own expense the appropriate equipment for playback.

G. Any reporter approved by the court may attend and record the trial or proceedings and prepare a bill of exceptions, certified to be true and complete by the reporter and file the same with the court. Proposed amendments not agreed to shall be heard and determined by the court as provided in section D of this rule. The completed bill of exceptions shall be filed in the court within the time provided by these rules.

H. Statement of Costs. The certificate of the reporter shall include a statement of the cost of the bill of exceptions and a showing that such amount is one permitted to be charged by Neb. Rev. Stat. § 25-1140.09.

Sections 48-169, 48-182, R.R.S. 1998, and 48-163, 48-179, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 15

RECORDS CHECKED OUT

Transcripts and bills of exceptions may be checked out by counsel for not more than 7 days. Counsel shall pay postage for records mailed to their offices. Counsel may obtain an extension of time for keeping the record in a case by sending a letter to the clerk of the compensation court, setting forth the case number, caption of the case, and a request to keep the record for an additional 7 days. Counsel failing to return records when requested by the clerk may be penalized by appropriate sanctions, including suspension of the privilege to check out records from the clerk's office.

Section 48-163, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 16

BRIEFS

A. Time for Filing. Briefs must be filed within the times stated in the rules if a party or parties wish to submit briefs.

No extensions of time will be allowed except upon a showing of exceptional cause. Neither the stipulation of the parties nor the press of other business constitutes exceptional cause.

1. Appellant's briefs, if any, must be served and filed as follows:
   a. No request for preparation of bill of exceptions filed: one month from the date the Application for Review is filed in the court.
   b. Request for preparation of bill of exceptions filed: 14 days after the date the bill of exceptions is due to be filed. If the bill of exceptions needs to be mailed to the appellant, 3 days are added to allow for delivery time.
2. Appellee's brief, if any, must be served and filed within 14 days after the date that appellant's brief is due. If service of appellant's brief is by mail, 3 days are added.
3. Appellant's reply brief, if any, must be served and filed within 14 days after appellee has served and filed briefs. If service of appellee's brief is by mail, 3 days are added.
4. Briefs may not exceed the following page lengths: original submission (combined total of appellant's brief and reply brief, or length of appellee's brief), 50 pages. These page limitations are exclusive of the cover, the table of contents, the table of cases, statutes, and authorities; and the certificate of mailing, but inclusive of all other pages and materials, including appendixes, indexes, exhibits, and other documents of any nature, character, kind, or description whatsoever.
5. Service of two copies of the brief shall be made either on the opposing party, if not represented by counsel, or the attorney of record for the party, if represented, and upon all other parties participating in the appeal. Service may be made either by personal service or by mail. Proof of service may be shown by the affidavit of the person making service or by the receipt of the party or attorney served or by certificate of the attorney causing the service to be made.
6. Four copies of each brief, together with proof of service, shall be filed in the office of the clerk on or before the date the brief is due.

B. General Rules for Preparation of Briefs. In the preparation of the brief, the following general rules shall be observed:

1. Reference to the transcript shall be made by setting forth in parenthesis the capitol letter "T" followed by the page of the transcript, as, for example, (T26).
2. References to questions, answers, objections, motions, rulings, or any other matters found in the bill of exceptions shall be made by setting forth in parentheses the numbered page and line in the bill of exceptions where found, as, for example, (156:12). The number preceding the colon should represent the page of the bill of exceptions where found, and the number following the colon, the line.
3. References to exhibits in the bill of exceptions shall be made by setting forth in parentheses the capital letter E, followed by the number of the exhibit, followed by a comma and the page of the exhibit on which the material to which reference is made appears, followed by a colon and the page of the bill of exceptions where the exhibit was offered and received or refused, followed by a comma and the page where the exhibit is found, as, for example, (E5,3:92, 95).
4. Every reference to a reported case shall set forth the title thereof, the volume and page where found, the tribunal deciding the case, and the year decided. If the cited opinion is long, it shall also refer to the page where the pertinent portion of the opinion is found. Nebraska cases shall be cited by the state reports, but may include citation to such other reports as may contain such cases.
5. If a current statute is relied upon, it must be cited from the last published revision or compilation of the statutes, or supplement thereto, if contained therein; if not contained therein, to the session laws wherein contained, or the legislative bill as enacted.
6. Citations to textbooks, encyclopedias, and other works shall give the title, edition, year of publication, volume number, section, and page where found.

C. Content of Briefs.

1. The brief of appellant shall contain the following sections, under appropriate hearings, and in the order indicated:
    a. The title page, which is the cover;
    b. A table of contents with page references, and an alphabetically arranged table of cases, statutes, and other authorities cited, with references to the pages of the brief where cited;

c. The statement of the case shall contain the following, in the order indicated: (1) The nature of the case; (2) the issues actually tried in the court below; (3) how the issues were decided and what judgment or decree was entered by the trial court; and (4) the scope of the court's review;

d. A separate, concise statement of each error a party contends was made by the trial court, together with the issues pertaining to the assignments of error. Each assignment of error shall be separately numbered and paragraphed, bearing in mind that consideration of the case will be limited to errors assigned and discussed. The court may, at its option, notice a plain error not assigned;

e. Propositions of law shall be contained in separate, numbered paragraphs, and shall state concisely and without argument or elaboration the legal propositions urged as controlling. Only propositions discussed in the argument shall be stated. Each proposition of law shall be followed by a list of supporting authorities. Preference in citation shall be given to those authorities deemed most important. Authorities cited under any proposition must be quoted or otherwise discussed in the argument;

f. The statement of facts shall be made in narrative form, and shall consist of so much of the substance of the record as is necessary to present the case. Each and every recitation of fact, whether in the statement of facts or elsewhere in the brief, shall be annotated to the record in the manner set forth in part B of this rule; and

g. The argument shall present each question separately, and shall present each proposition of law as best sets forth the contentions of the party. Authorities relied upon shall be quoted or otherwise discussed. A party may make such further statements of fact or quotations from the record as deemed necessary to properly present the question, supporting such facts by appropriate references to the record.

2. The brief of appellee shall contain the following matters, in the order indicated:

a. Table of contents and table of cases cited;

b. Statement of the case, if appellant's statement thereof is not accepted as correct;

c. Propositions of law;

d. Statement of facts, if appellant's statement is not accepted as corrected or is amplified. Each and every recitation of fact shall be annotated to the record in the manner set forth in part B of this rule, no matter where in appellee's brief such recitation is made; and

e. Argument.

3. Where the brief of appellee presents a cross-appeal, it shall be noted on the cover of the brief and it shall be set forth in a separate division of the brief. This division shall be headed "Brief on Cross-Appeal" and shall be prepared in the same manner and under the same rules as the brief of appellant.

4. The reply brief shall be prepared in the same manner as the brief of appellee. The answer of appellant to any cross-appeal shall be set forth in a separate division of the reply brief and shall be headed "Answer of Brief on Cross-Appeal," and shall be noted on the cover of the brief.

D. Cases Involving Constitutional Questions. A party presenting a case involving the federal or state constitutionality of a statute must file and serve a separate written notice thereof with the court clerk at the time of filing such party's brief. If the Attorney General is not already a party to an action where the constitutionality of the statute is in issue, a copy of the brief assigning unconstitutionality must be served on the Attorney General within 5 days of the filing of the brief with the clerk of this court; proof of such service shall be filed with the court clerk.

E. Hearing not Delayed. The hearing of a case will not be delayed by default of either party in serving or filing briefs, unless, for good cause shown, it is otherwise ordered.

Section 48-182, R.R.S. 1998.
Effective date July 1, 1997.

RULE 17

SCHEDULING, ARGUMENT, AND SUBMISSION

A. Cases are scheduled for oral argument as soon as the appellee's brief is due to be filed.

B. Either party may file a motion with the court requesting that the case be advanced for argument. A party seeking an advancement of oral argument shall

file a showing in support of said motion setting out the reasons said case should be advanced for oral argument.

C. Call. The call is the final schedule of oral arguments for a specified session of the court. Cases are heard in the ordered listed. Cases will not be continued to another session of the court after scheduling on the call unless leave is granted by the court. A party may file an application for continuance, which must be accompanied by a showing of exceptional cause.

D. The court will hear oral argument as scheduled.

E. Oral Argument.

1. Unless otherwise ordered by the court, oral argument shall not exceed 10 minutes per side. The appellant is entitled to open and conclude the argument within the time limits herein set out.
2. On the court's own motion or on application, additional time may be granted. An application must be filed within 10 days after the call is mailed. Such application must be accompanied by a showing of good cause.

F. Non-Appearance of Parties. If the appellee fails to appear to present argument, the court will hear argument on behalf of the appellant, if present. If the appellant fails to appear, the court may hear argument on behalf of the appellee, if present. If neither party appears, the case will be decided on the briefs unless the court shall otherwise order.

G. Unless otherwise directed by the court, the parties may elect to waive oral argument and submit a case solely on the briefs.

Sections 48-163, 48-179, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 18

SUMMARY DISPOSITIONS

A. When the court determines that any one or more of the following circumstances exist and are dispositive of the case submitted to the court for decision, the judgment or order may be affirmed in the following manner: "AFFIRMED":

1. The judgment is based on findings of fact which are not clearly wrong.
2. No error of law appears, and the court also determines that a detailed opinion would have no precedential value.

B. When the court determines it lacks jurisdiction the appeal may be dismissed in the following manner: "APPLICATION FOR REVIEW DISMISSED. NO JURISDICTION."

Section 48-179, R.S. Supp., 2002.
Effective date July 28, 1999.

RULE 19

OPINIONS

A. Release of Written Opinions. After the review hearing, the court will prepare a written opinion in cases where the court believes explanation of its decision is required or that the case is of value as a precedent.

B. Copies Mailed. A copy of each opinion will be mailed to all attorneys and pro se parties whose names and addresses appear on briefs submitted in connection with a case.

C. Official Version. The official opinion, order, or other judgment of the court shall be the original, signed version which is on file with the Clerk of the Court.

Section 48-163, R.S. Supp., 2002.
Effective date December 1, 1999.

RULE 20

DISMISSAL OF APPEAL

A. Parties. An Application for Review may be dismissed by stipulation of the parties.

B. Form. The Stipulation to dismiss must be in typewritten form.

Section 48-179, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 21

COSTS

Except as otherwise provided by law, if an appeal is dismissed, costs shall be taxed against the appellant unless otherwise agreed by the parties or ordered by the court; if a judgment is affirmed, costs shall be taxed against the appellant unless otherwise ordered; if a judgment is reversed, costs shall be taxed against the appellee unless otherwise ordered; if a judgment is affirmed or reversed in part, or is vacated, costs shall be allowed only as ordered by the court.

Costs incurred in the preparation and transmission of the record and the costs of the transcript shall be taxed as costs of the appeal in favor of the party entitled to costs under this rule.

When unnecessary costs have been made by either party, the court may order the same to be taxed to the party making them, without reference to the disposition of the case.

Section 48-178, R.R.S. 1998.
Effective date July 1, 1997.

RULE 22

APPEAL AFTER REVIEW

Any appeal from the judgment of this court after a review shall be prosecuted and the procedure shall be in accordance with the general laws of the state and procedures regulating appeals in actions at law from the district courts except as provided in sections 48-182 and 48-185, Revised Statutes of Nebraska and except that no motion for new trial, including any motion for reconsideration or petition for rehearing, shall be filed in this court.

Section 48-185, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 23

DISMISSAL DOCKET

As soon as practical after the 1st of January of each year and the 1st of July of each year, the clerk shall prepare a list of all pending cases in which no action has been taken for at least 6 months prior thereto. The court shall examine the list and, in those cases in which it is deemed proper, shall enter an order to show cause why such cases should not be dismissed for want of prosecution. A written response to the order to show cause must be filed in the action and a copy of the same provided to other counsel and the court within 30 days, or said action shall be dismissed.

Section 48-163, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 24

MEETINGS OF THE COURT

In addition to the biennial meeting required by section 48-155, Revised Statutes of Nebraska, the court may hold other meetings at any time on call of the presiding judge or upon request of a majority of the court. At such meetings any business of the court not at variance with statutory provisions may be transacted.

Sections 48-162, R.R.S. 1998, and 48-155, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 25

COMPLIANCE WITH RULES

Wherever in these rules any requirement is made of the employer in a compensation case, compliance therewith by the employer's insurer or, if the employer is a member of a risk management pool, compliance therewith by such pool, will be deemed to be compliance by the employer.

Sections 48-144, R.R.S. 1998, and 48-163, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 26

MEDICAL FEE SCHEDULE

The Nebraska Workers' Compensation Court Schedule of Medical And Hospital Fees, effective July 1, 2004, when used in conjunction with the General Instructions, Ground Rules, unit values, and conversion factors set out in such schedule hereby is adopted as a fee schedule to be used in setting maximum payments for medical, surgical, and hospital services in workers' compensation cases. Copies of the schedule shall be available for examination in the office of the court in Lincoln, Nebraska, and the court's courtroom in Omaha, Nebraska and will be made available for purchase upon request.

Section 48-120, R.S. Supp., 2002.
Effective date July 1, 2004.

RULE 27

INSURANCE AND SELF INSURANCE

Repealed effective July 1, 2000.

RULE 28

CORPORATE EXECUTIVE OFFICER WAIVER

Repealed effective January 1, 2003.

RULE 29

FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY OR ILLNESS

A. In every case of reportable injury occurring in the course of employment, whether resulting from accident or from occupational disease, the employer or its insurer or risk management pool shall file a report thereof with the compensation court, specifically stating the nature and extent of the injury. Such first report of alleged occupational injury or illness shall be filed within forty-eight hours in case of each injury resulting in either a death or in the hospitalization of five or more employees from one accident and within seven days in case of all other reportable injuries after the employer or insurer or risk management pool has been given notice or has knowledge of any such injury.

B. The first report of alleged occupational injury or illness shall be filed in writing or by electronic means, if such electronic means and the content of the electronic filing is approved by the compensation court. Written reports shall be made by means of the First Report of Alleged Occupational Injury or Illness (Form 1), an exact copy of which appears on the following two pages. The mandatory fields identified on the back of the First Report of Alleged Occupational Injury or Illness (Form 1) must be completed before the report will be deemed filed and accepted by the court. Facsimile copies will not be accepted. Blank forms for written reports are furnished by the compensation court upon request.

C. Beginning no later than July 1, 2000, all first reports of alleged occupational injury or illness filed by or on behalf of an insurer, risk management pool, or self insured employer shall be filed electronically in the form and manner and to include the content prescribed by the compensation court. In the alternative, an implementation plan shall be approved by the court no later than July 1, 2000. No report filed by electronic means shall be deemed filed until the electronic transmission has been received and accepted by the court.

D. Notwithstanding the provisions of this rule with respect to electronic filings, first reports of alleged occupational injury or illness in cases of injury resulting in either death or hospitalization of five or more employees from one accident may be filed by any means necessary to ensure timely filing.

Sections 48-144, 48-144.01, 48-165, R.R.S. 1998, and 48-163, R.S. Supp., 2002. Effective date April 25, 2002.

Nebraska Workers' Compensation Court

First Report of Alleged Occupational Injury or Illness

NWCC Form 1
Revised 03-02

Employer

Employer FEIN _____ SIC Code _____ Report Purpose _____ OSHA Log Case # _____

Employer Name(s) _____

Address _____

_____

City _____

State _____ Zip Code _____ Phone _____

Insured Name *(If different from employer name)*

Insured Address *(If different)*

Location _____

Insurance Carrier

Carrier FEIN _____

Administrator FEIN _____

Name _____

Address _____

_____

City _____

State _____ Zip Code _____ Phone _____

Policy Number _____

Policy Period: From _____ To _____

Insurance Carrier/Self-Insured Code # _____

Claim Administrator *(Name, address & phone number)*

Self Insured ❑ *Check if Appropriate*

Claim Administrator Claim # _____

Jurisdiction Claim # _____

Insured Report # _____ Jurisdiction _____

Employee

Name *(Last, First, Middle)* _____

Address _____

_____

City _____

State _____ Zip Code _____ Phone _____

Date of Birth | Social Security Number | Date Hired

Full Pay for DOI Yes ❑ No ❑

Salary Continued Yes ❑ No ❑

Number of Days Worked Per Week _____

Sex Male ❑ Female ❑

Number of Dependents _____

Marital Status
Married ❑
Separated ❑
Unmarried ❑
Unknown ❑

Wage $ _____
Hourly ❑
Daily ❑
Weekly ❑
Bi-Weekly ❑
Monthly ❑

Occupational Job Title

Occupational Code _____

Date Employee Began Work-Related Duties _____

Employment Status FT ❑ PT ❑ Other ❑

Occurrence/Treatment

Date of Injury/Illness | Time Employee Began Work AM ❑ PM ❑ | Time of Occurrence (Cannot be determined ❑) AM ❑ PM ❑ | Last Work Date

Where Did Injury/Illness Occur?
County _____ State _____ Zip _____

Did Injury/Illness Occur On Employer's Premises? Yes ❑ No ❑

Date Employer Notified | Date Disability Began | Date Returned to Work | If Fatal, Give Date of Death

Type of Injury/Illness *(Briefly describe the nature of the injury or illness; e.g. lacerations to forearm)* | Nature of Injury Code

Part of Body Affected *(Indicate the part of the body affected by the injury/illness; e.g. right forearm, lowerback; and how it was affected)* | Part of Body Code

How Injury/Illness Occurred *(Describe activity and tools, materials, equipment the employee was using; how injury occurred)* | Cause of Injury Code

Initial Treatment:
No medical treatment ❑
First aid by employer ❑
Minor clinic/hospital ❑
Emergency Room ❑
Hospitalized overnight ❑
Hospitalized > 24 hours ❑
Future major medical/lost time ❑

Name of physician or other health care provider:

Date Administrator Notified | Form Preparer's Name, Title and Phone | Date Prepared

General Instructions

Items in bold are mandatory fields. First Report of Injury or Illness (*FROI*) without this information will be returned.

Item—Definitions

Employer:

- Employer FEIN—the employer/insured's Federal Employer's Identification Number.
- SIC Code—**S**tandard **I**dentification **C**lassification code which represents the nature of the employer's business.
- Report Purpose—defines the specific purpose of the transaction. (Examples: original=00; cancel=01; change=02; denial;=04; correction=co).
- OSHA Log Case #—the Log Case number required for reporting to OSHA.
- **Employer Name—include all business names/doing business as *(dba)***
- Address (including city,state,zip)—the address of the employer's actual location where the employee was employed at the time of the injury.
- Phone—phone number at the employer's facility.
- **Insured Name (*if different from employer*)—the named insured on the policy or the financially responsible self–insured employer.**
- Insured Address (***if different***)—mailing address of the insured.
- Location—a code defined by the insured/employer which is used to identify the employer's location.

Insurance Carrier:

- **Carrier FEIN—carrier's Federal Employer's Identification Number.**
- Administrator FEIN—administrator's Federal Employer's Identification Number.
- **Name—the worker's compensation insurer, approved self insured, or intergovernmental risk management pool.**
- **Address— address of insurer (including city, state, zip).**
- Phone—phone number of insurer.
- Claim Administrator (name, address, & phone)—enter the name, address and phone number of the carrier, third party administrator, risk management pool, or self–insurer responsible for administering the claims, if different from carrier information.
- Policy #—the number assigned to the contract/policy for that employer.
- Policy Period—the effective and expiration dates of the contract.
- Insurance Carrier/Self Insured Code #—for insurance carriers, the number assigned by the Nat'l Assn. of Insurance Commissioners. For self-insured employers, the code number assigned by the court.
- **Self Insured—check if appropriate.**
- **Claim Administrator Claim #—identifies a specific claim within a claim administrator's claims processing system.**
- Jurisdiction Claim #—number assigned by the court when the initial First Report is accepted.
- Insured Report #—a number used by the insured to identify a specific claim.
- Jurisdiction—the governing body or territory whose statutes apply (NE).

Employee:

- **Name—give full name as shown on payroll. (Avoid initials if possible).**
- **Address—enter employee's current city and state.** (Address and zip code information is optional)
- Date of Birth—the date the injured worker was born.
- **Social Security Number.**
- Date Hired—the date the injured worker began his/her employment with the employer.
- Full Pay for DOI (date of injury)—check one.
- Salary Continued—check one.
- Number of Days Worked Per Week—the number of the employee's regularly scheduled work days per week.
- Sex—check one.
- Number of Dependents—the number of dependents as defined by the administering jurisdiction.
- Marital Status—check one.
- Wage—check one and state wage.
- Occupational Job Title—the primary occupation of the claimant at the time of the accident.
- Occupational Code—Standard Occupational Classification code used to identify the primary occupation of the employee at the time of the accident.
- Date Employee Began Work–Related Duties—date pertaining to employee's present occupation.
- Employment Status—check one.

Occurrence/Treatment:

- **Date of Injury/Illness—date on which the accident occurred**.
- Time Employee Began Work—time employee began work for that date.
- Time of Occurrence—time of day the injury occurred.
- Last Work Date—the last paid work day prior to the initial date of disability.
- **Where Did Injury/Illness Occur—complete county, state, and zip code.**
- Did Injury/Illness Occur On Employer's Premises—check one.
- Date Employer Notified—the date that the injury was reported to a representative of the employer.
- Date Disability Began—if not disabled answer none and skip questions.
- Date Returned to Work—if injured has returned to work, complete this question.
- **If Fatal, Give Date of Death**, (Conditional if employee died as a result of a work-related injury.)
- **Type of Injury/Illness—describe the nature of injury.**
- Nature of Injury Code—the code which corresponds to the nature of the injury sustained by the employee.
- Part of Body Affected—the part of the body to which the employee sustained injury.
- Part of Body Code—the code which corresponds to the Part of the body to which the employee sustained injury.
- **How Injury/Illness Occurred—a free-form description of how the accident occurred and the resulting injuries.**
- **Cause of Injury Code—the code that corresponds to the cause of injury**
- Initial Treatment—check one.
- Name of physician or other health care provider—provide name of physician or other health care provider that treated employee for injury.
- Date Administrator Notified—the date the claim administrator who is processing the claim received notice of the loss or occurrence.
- Form Preparer's Name, Title and Phone.
- Date Prepared—date form was actually completed.

Type or print neatly your response in ink.

RULE 30

SUBSEQUENT REPORT

A. A Subsequent Report shall be filed with the court by the employer or its insurer or risk management pool. Such Subsequent Report shall be filed:

1. Within fourteen days following initial payment of workers' compensation benefits. A report must be filed even in cases where only medical or other non-income benefit payments have been made.
2. Within fourteen days following the denial of a claim or a change to a previous report.
3. On the semi-annual anniversary of the date of injury, and every 180 days thereafter until the case is closed.
4. Within fourteen working days following the closing of any case for which benefits have been paid.
5. Within fourteen days following payment pursuant to a final order, award, or judgment of the court, including an order approving a lump sum settlement or settlement agreement.
6. Within 30 days of receipt from the court of a notice of error and request for correction of a previously filed Subsequent Report.

B. On all Subsequent Reports filed with the court, cumulative weekly, medical, hospital, vocational rehabilitation and other benefit payments shall be included.

C. For cases in which the employer has continued to pay full salary, any portion of the full salary payment that was intended to apply to workers' compensation benefits shall be reported in accordance with this rule.

D. The Subsequent Report shall be filed in writing or by electronic means, if such electronic means and the content of the electronic filing is approved by the court. Written reports shall be made by means of the Subsequent Report (Form 4), an exact copy of which appears on the two pages following this rule. Facsimile copies will not be accepted. Blank forms for written reports are furnished by the court upon request.

E. Beginning no later than October 1, 2004, all Subsequent Reports filed by or on behalf of an insurer, risk management pool, or self insured employer shall be filed electronically in the form and manner and to include the content prescribed by the compensation court. In the alternative, an imple-

mentation plan shall be approved by the court no later than October 1, 2004. No report filed by electronic means shall be deemed filed until the electronic transmission has been received and accepted by the court.

Sections 48-144, 48-165, R.R.S. 1998, and 48-163, R.S. Supp., 2002. Effective date May 12, 2004.

Nebraska Workers' Compensation Court—SUBSEQUENT REPORT

NWCC FORM 4
REVISED 03-02

EMPLOYEE NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER	DATE OF INJURY	REPORT EFFECTIVE DATE	JURISDICTION

DATE DISABILITY BEGAN	PRE-EXISTING DISABILITY? ❑ YES ❑ NO	DATE OF REPRESENTATION	DATE OF DEATH	REPORT PURPOSE

RELEASED/ RETURNED TO WORK *(RTW)* DATE	***RELEASED/ RTW QUALIFIER***			AGENCY CLAIM NUMBER
	RTW WITHOUT RESTRICTIONS ❑	RELEASED RTW WITHOUT RESTRICTIONS ❑		
	RTW WITH RESTRICTIONS ❑	RELEASED RTW WITH RESTRICTIONS ❑		

NUMBER OF DEPENDENTS	***DEATH DEPENDENT/ PAYEE RELATIONSHIP***						DATE OF MAXIMUM MEDICAL IMPROVEMENT
	WIDOW ❑	WIDOWER ❑	CHILDREN ❑	SIBLINGS ❑	PARENTS ❑	OTHER ❑	

PERMANENT IMPAIRMENT	BODY PART	PERCENT	BODY PART	PERCENT	BODY PART	PERCENT

EMPLOYER NAME	FEIN	INSURED REPORT NUMBER

WAGE

WAGE PERIOD	AVERAGE WEEKLY WAGE	NUMBER OF DAYS WORKED PER WEEK	SALARY CONTINUED IN LIEU OF COMP?
❑ WEEKLY ❑ BI-WEEKLY ❑ MONTHLY ❑ SEMI-MONTHLY			❑ YES ❑ NO

PAYMENTS

PAYMENT TYPE	PAID FROM *(MM/DD/YYYY)*	PAID THROUGH *(MM/DD/YYYY)*	# WEEKS PAID	# DAYS PAID	WEEKLY PAYMENT AMOUNT	AMOUNT PAID TO DATE

BENEFIT ADJUSTMENTS

BENEFIT ADJUSTMENT TYPE	WEEKLY AMOUNT *(+ OR -)*	START DATE

BENEFIT ADJUSTMENTS

BENEFIT ADJUSTMENT TYPE	WEEKLY AMOUNT *(+ OR -)*	START DATE

PAID-TO-DATE

PAID TO DATE TYPE	PAID TO DATE AMOUNT

PAID-TO-DATE

PAID TO DATE TYPE	PAID TO DATE AMOUNT

CLAIM ADMINISTRATION

INSURER NAME	FEIN	***CLAIM STATUS***			
			OPEN ❑	REOPENED ❑	
			CLOSED ❑	REOPENED/CLOSED ❑	

THIRD PARTY ADMINISTRATOR NAME	FEIN	***CLAIM TYPE***			
			MEDICAL ONLY ❑	NOTIFICATION ONLY ❑	BECAME LOST TIME ❑
			INDEMNITY ❑	BECAME MED ONLY ❑	TRANSFER ❑

CLAIM ADMINISTRATOR CLAIM NUMBER	***AGREEMENT TO COMPENSATE***	
		WITHOUT LIABILITY ❑
		WITH LIABILITY ❑

CLAIM ADMINISTRATOR ADDRESS	LATE REASON
PHONE # _____	
CITY _____ STATE _____ ZIP CODE _____	DATE PREPARED
FORM PREPARER'S NAME	PREPARER'S PHONE

General Instructions

Items in bold are mandatory fields. Subsequent Report of Injury (*SROI*) without this information will be returned.

Item—Definitions

- Employee Name—the injured worker's legally recognized name.
- **Social Security Number—a number assigned by the Social Security Administration used to identify the employee.**
- **Date of Injury—date on which the accident occurred.**
- Report Effective Date**—**The date the payment which causes the form to be filed was made.
- **Jurisdiction—the governing body or territory whose statutes apply (NE).**
- Date Disability Began—the first day on which the employee originally lost time from work due to the occupational injury or disease or as otherwise defined by the jurisdiction.
- Pre-Existing Disability—identifies the existence of a disability that existed prior to the injury.
- Date of Representation—the date the claim administrator became aware that the claimant had secured legal representation.
- Date of Death—the date the injured worker died.
- Report Purpose—The MTC (maintenance type code) that corresponds to the reason the form is being filed.
- Released/Returned to Work *(RTW)* Date—the date, following the most recent disability period, on which the employee actually returned to work, or was released to return to work, as identified by the return to work qualifier.
- Released/RTW Qualifier—a code identifying the employee's return to work status, with or without physical restrictions.
- Agency Claim Number—the number assigned by the Nebraska Workers' Compensation Court to identify a specific claim.
- Number of Dependents—the number of dependents as defined by the Nebraska Workers' Compensation Act.
- Death Dependent/Payee Relationship—the relationship of the dependent(s)/payee(s) to the deceased employee; to which relationship and benefit entitlement may be determined by an adjudicator's decision for distribution of the death benefit.
- Date of Maximum Medical Improvement—the date after which further recovery from or lasting improvement to an injury or disease can no longer be anticipated based upon reasonable medical probability.
- Permanent Impairment Body Part Code—a code referencing the part(s) of body permanently impaired.
- Permanent Impairment Percentage—report the amount of part(s) of body or functional abnormality or loss which results from the injury and exists after the date of maximum medical improvements.
- Employer Name—the name of the business entity of the insured where the employee was employed at the time of the injury.
- Employer FEIN—the FEIN of the employer where the employee was employed at the time of the injury.
- Insured Report Number—a number used by the insured to identify a specific claim.

Wage

- Wage Period—a code indicating the time period during which the wage was earned.
- Average Weekly Wage—the average wage of the employee at the time of injury as calculated by the claims administrator or jurisdictional authority for the wage period.
- Number of Days Worked Per Week—the number of the employee's regularly scheduled work days per week.
- Salary Continued In Lieu of Comp—the employer has paid or is paying the employee's salary in lieu of compensation during an absence caused by a work-related injury.

Payments

- Payment Type—a code that identifies the payment being made.
- Payment From Date—the first start date of a benefit period for which benefits were paid.
- Payment Through Date—the last date of a benefit period for which benefits were paid.
- Payment Weeks Paid—the number of whole weeks for a specific payment code.
- Payment Days Paid—the number of days paid for a specific payment code.
- Payment Weekly Amount—the net weekly rate for the payment code being paid.
- Payment Paid to Date—the cumulative amount paid for the payment code being paid.

Benefit Adjustments

- Benefit Adjustment Type— DO NOT USE. Reserved for future use.
- Benefit Adjustment Weekly Amount— DO NOT USE. Reserved for future use.
- Benefit Adjustment Start Date— DO NOT USE. Reserved for future use.

Paid-To-Date

- Paid to Date Type—a code that identifies the type of paid to date/reduced earnings/recoveries made.
- Paid to Date Amount—the amount defined by the paid to date/reduced earnings/recoveries code.

Claim Administrator

- Insurer Name—the name of the insurer or self insured assuming the employer's financial responsibility for workers' compensation claim(s).
- **Insurer FEIN—insurer's Federal Employer's Identification Number.**
- Third Party Administrator Name—the name of the Third Party Administrator contracted to adjust the claim on behalf of the carrier or self insured.
- Third Party Administrator FEIN—the Federal Employer's Identification Number of the third party administrator's independent adjuster, contracted to adjust the claim on behalf of the insurer or self insured.
- **Claim Administrator Claim Number—identifies a specific claim within a claim administrator's claims processing system.**
- Claim Administrator Address—the address, including zip code, and telephone number of the claim administrator.
- Form Preparer's Name— the name of the person completing the form.

Claim Status

- **Claim Status—a code representing the current status of the claim.**
- Claim Type—a code representing the current benefit classification of the claim as interpreted by the jurisdiction
- Agreement to Compensate—a code used to identify the condition under which compensation benefits are being paid.
- Late Reason—a code which identifies the reasons payment/report was not made within a jurisdiction's requirements.
- Date Prepared—the date the form preparer completed the form.
- Preparer's Phone—the phone number of the person completing the form.

Type or print neatly your response in ink.

RULE 31

PERIODIC REPORT OF CONTINUING COMPENSATION

Repealed effective July 1, 1995.

RULE 32

REPORTING OF COMPENSATION INSURANCE

A. The insurer shall file a report as required by section 48-144.02 with the court or its agent within ten days after a policy is written, renewed, extended, or reinstated. The insurer shall give notice as required by section 48-144.03 to the court or its agent if the insurer or employer intends to cancel a policy within the policy period, or if the insurer intends to nonrenew a policy other than one issued under the assigned-risk system pursuant to section 48-146.01. Any such report or notice shall be provided in writing or by electronic means, if such means is approved by the court or its agent. Approval of such electronic means by the agent shall constitute approval by the court. If such report or notice is filed with the court or its agent by electronic means, pursuant to such an approval, it shall be deemed given upon receipt. Written notice as required by section 48-144.03 shall be deemed given upon the mailing of such notice by certified mail to the court or its agent. Written reports or notices filed with the court shall be made by means of the Record of Compensation Insurance (Form 12). Written reports or notices filed with an agent of the court shall be made by means of forms and formats prescribed by the agent and approved by the court. Insurers who file such reports or notices with the agent are not required to file the Form 12 with the court. Receipt of such reports or notices by the agent shall constitute receipt by the court. Insurers shall continue to provide notice to employers as required by section 48-144.03.

B. A cancellation by the insurer within the policy period shall not be effective until thirty days after the giving of notice by the insurer to the court or its agent and to the employer, except that such cancellation may be effective ten days after the giving of such notice if such cancellation is based on (i) nonpayment of premium, (ii) failure of the employer to reimburse deductible losses as required under the policy, or (iii) failure of the employer, if covered under the assigned-risk system pursuant to section 48-146.01, to comply with sections

48-443 to 48-445. A cancellation by the employer within the policy period shall not be effective until ten days after the giving of notice by the insurer to the court or its agent. If the employer has secured insurance with another insurer which would cause double coverage, a cancellation by the insurer or employer shall be made effective as of the effective date of such other insurance. A nonrenewal by the insurer of a policy other than one issued under the assigned-risk system pursuant to section 48-146.01 shall not be effective until thirty days after the giving of notice by the insurer to the court or its agent and to the employer.

C. If a policy is automatically renewed by the insurer and the employer subsequently declines to accept such policy, it shall be considered a cancellation by the employer within the policy period and section 48-144.03(1)(b) shall apply.

D. If an endorsement changes neither the insured's name, address, the effective date nor the expiration date, and does not affect the policy number, then it is not necessary to file another report with the court or its agent.

E. For multiple entities with the same policy number, each different name and address shall be reported to the court or its agent. If there are multiple locations, the locations shall be listed separately.

F. The Form 12P shall be filed by the risk management pool with the court within ten days after the pool is organized showing the name and local addresses of its members. Within ten days after any new member is accepted or whenever any member of a pool voluntarily terminates membership or is involuntarily terminated, the Form 12P shall be filed with the court showing the name, local address and effective date of termination or joinder of any single member. For multiple entities within the jurisdiction of a single member, each different name and address shall be listed on the Form 12P or on an attached sheet. If there are multiple locations in Nebraska, the locations shall be listed on the Form 12P or on an attached sheet.

G. Exact copies of the Record of Compensation Insurance (Form 12) and the Record of Compensation Insurance – Form 12P appear on the next two pages following.

Sections 48-144.02, 48-144.03, 48-146.03, R.R.S. 1998, and 48-144.04, 48-146.01, R.S. Supp., 2002.
Effective date July 1, 1997.

NEBRASKA
RECORD OF COMPENSATION INSURANCE

To be Used to Report Compensation Insurance Issuance, Cancellation, Renewal, Nonrenewal, or Reinstatement.

MAIL TO: NEBRASKA WORKERS' COMPENSATION COURT, P.O. BOX 98908, LINCOLN, NE 68509-8908 (402) 471-6468

1. Name and Address of Insurance Carrier

Assigned Risk? ❑ Yes ❑ No

10. Insured's Name & Address

2. Policy Number

3. NE Dept. of Ins. Company Number (5 digit)

11. Any Prior Business Names

4. Deductible Amount

5. If No Deductible
❑ Not Chosen
❑ Not Offered

6. Effective Date

7. Expiration Date

12. List **All Nebraska** location addresses with the current business name
(If additional space is needed, use back of form or attach separate sheet.)

8. Transaction (Complete One)

❑ New Policy

❑ Cancellation Cancellation Date

_____
For Effective Date See NE Rev. Stat. 48-144.03 or Rule 32. Must be sent by certified mail.

❑ Renewal or Extension

❑ Nonrenewal
(Effective 30 days after certified mailing)

❑ Reinstatement Reinstatement Date

_____

9. Reason for Cancellation or Nonrenewal

13. Insured's Federal Identification Number (FIN)

Prepared By (Please Type)

Preparer's Telephone #

Date

NWCC FORM 12 (REV. 6/95)

Nebraska Record of Compensation Insurance — Form 12P
Intergovernmental Risk Management Pool

To be used to provide information on each pool member involved in the event of organization, joinder, or termination, within 10 days of the event. Only one member of a pool may be reported on a Form 12P.

1. Name and Addressof Member of Risk Management Pool:

   _____

   _____

   _____

   Phone: _____ Dept. of Insurance Code: _____

2. Name of Member: _____

3. Event Reported (check one and give the effective date):

   ❑ Initial Organization of Pool Effective Date: _____

   ❑ New Member Effective Date: _____

   ❑ Termination of Member Effective Date: _____

4. For workers' compensation purposes, list any separately named entities under the jurisdiction of this member from which employees work and the location. (If additional space is needed, attach a separate sheet.)

   Name Address FEIN

   _____

   _____

   _____

   _____

5. Name of Pool Administrator: _____

   Address: _____

   _____

6. Prepared by (please type): _____

   Phone: _____

7. Mail to: **Nebraska Workers' Compensation Court**
   PO Box 68908
   Lincoln NE 68509-8908
   402-471-6468 or 800-599-5155

RULE 33

FIRST TREATMENT MEDICAL REPORTS

Words in italics are defined in Rule 49.

In all cases involving medical treatment, a report by the treating *physician* shall be furnished to the employer within fourteen days following the first treatment specifically setting forth the nature and extent of the injury or disease. The current Form HCFA – 1500 shall be used to meet the requirements of this rule.

Sections 48-165, R.R.S. 1998, and 48-120, R.S. Supp., 2002.
Effective date October 27, 1998.

RULE 34

30-DAY MEDICAL REPORT

Repealed effective October 27, 1998.

RULE 35

BLANK FORMS

Upon request, copies of blank forms required or used by the court will be furnished to employees, employers, insurers, risk management pools, or other persons having need thereof, in any quantity needed, to the extent that such supplies are available. The court may charge a fee sufficient to pay the costs incurred in the preparation and delivery of the forms. Employers, insurers, risk management pools, or others may furnish and use their own forms providing such forms are first approved by the court.

Sections 48-165, R.R.S. 1998, and 48-163, R.S. Supp., 2002.
Effective date December 1, 1999.

RULE 36

ELIGIBILITY AND APPROVAL OF VOCATIONAL REHABILITATION SERVICES

A. Vocational rehabilitation services shall be made available as soon as it has been medically determined that the employee is capable of undertaking such activity and that he or she is unable to perform suitable work for which he or she has had previous training or experience.

B. All voluntary vocational rehabilitation plans including on-the-job training, job placement, and formal retraining, must have prior approval of the court's vocational rehabilitation specialists.

1. Notice of all approved or disapproved plans shall be sent to the employee, and either the employer, its insurer or risk management pool, and the vocational rehabilitation counselor.
2. Such employer or insurer or risk management pool shall inform the court within 14 days of the date such notice is sent whether or not it will accept an approved plan and shall concurrently with such acceptance agree to the payment of temporary disability to the employee while he or she is undergoing vocational rehabilitation and making satisfactory progress.
3. The fee for the evaluation and for the development and implementation of the vocational rehabilitation plan shall be paid by the employer or his or her insurer or risk management pool.

Section 48-165, R.R.S. 1998, and sections 48-121, 48-162.01, 48-163, R.S. Supp., 2002.
Effective date May 12, 2004.

RULE 37

NOTIFICATION AND PROGRESS REPORTS

Words in italics are defined in Rule 49.

A. When a vocational rehabilitation counselor is retained for the purpose of evaluating an employee and, if necessary, developing and implementing a

vocational rehabilitation plan the court shall be so notified within five working days. Within 15 days after being retained the vocational rehabilitation counselor shall make initial contact with the employee. Within 30 days after being retained the vocational rehabilitation counselor shall meet with the employee and conduct an interview or assessment.

B. Within five working days after the end of each calendar month of service, the vocational rehabilitation counselor shall submit a monthly report showing the activity and type of service(s) provided.

C. In all cases involving an approved training plan, the court shall be provided with a copy of the class schedule from the employee at the start of each training period, school term, or grading or evaluation period and shall be provided with a copy of the grade transcript or a training progress report for the employee at the completion of each training period, school term, or grading or evaluation period. Failure of the employee or vocational rehabilitation counselor to provide a copy of the class schedule, grade transcript or a training progress report, or any other data requested by the court may result in a loss of funding or cancellation of the employee's vocational rehabilitation plan.

D. When an employee fails to make satisfactory progress or discontinues participating in an approved vocational rehabilitation plan, the court shall be immediately notified by the vocational rehabilitation counselor. The vocational rehabilitation counselor shall also promptly notify the employer or his or her insurer, in writing, when an employee has discontinued participating in an approved vocational rehabilitation plan.

E. Upon termination of vocational rehabilitation services or case closure, the vocational rehabilitation counselor shall notify the court within five working days of the reason for the termination or closure and the current employment status of the employee and such other information as the court shall require. A form developed by the court shall be used for this purpose.

F. Any reports provided to any party that are prepared by a vocational rehabilitation counselor or job placement specialist acting under the supervision of a vocational rehabilitation counselor shall be provided to all parties, with an additional copy sent directly to the employee.

G. Failure of a vocational rehabilitation counselor to comply with the reporting or notification requirements of this rule may cause the certification of

such counselor to be denied, *suspended, revoked*, or placed in a *probationary status*.

Section 48-165, R.R.S. 1998, and sections 48-162.01, 48-163, R.S. Supp., 2002.
Effective date December 19, 2000.

RULE 38

VOCATIONAL REHABILITATION COSTS

A. Costs of tuition, books, tools, and such other fees and costs as are deemed appropriate by the court shall be paid directly to the service provider or payor from the Workers' Compensation Trust Fund upon receipt of a training progress report, as required, and proper billing or other appropriate documentation.

B. When residence is required at or near the facility or institution away from the employee's customary residence and board and/or lodging is available at the training facility, such costs shall be paid directly to the training facility from the Workers' Compensation Trust Fund upon receipt of proper billing.

C. When residence is required at or near the facility or institution away from the employee's customary residence and board and lodging are available at the training facility or institution and the employee elects to utilize local housing in lieu of that available at the training facility or institution, the equivalent of the published cost of the training facility's or institution's board and lodging, but not local travel, may be paid directly to the employee from the Workers' Compensation Trust Fund. Such costs shall be established and approved by the court.

D. When residence is required at or near the facility or institution, away from the employee's customary residence and board and/or lodging is not available at the training facility, the reasonable cost of board, lodging and travel will be paid directly to the employee from the Workers' Compensation Trust Fund. Such costs shall be established and approved by the court.

E. When it is in the best interests of the employee to commute to and from the facility or institution rather than to reside at or near the facility or institu-

tion the reasonable cost of travel or the equivalent of the reasonable cost of room and board, whichever is lower, may be paid directly to the employee from the Workers' Compensation Trust Fund. Such costs shall be established and approved by the court.

Sections 48-162.01, 48-162.02, 48-163, R.S. Supp., 2002.
Effective date December 19, 2000.

RULE 39

CERTIFICATION OF VOCATIONAL REHABILITATION SERVICE PROVIDERS

Words in italics are defined in Rule 49.

A. In all cases requiring vocational rehabilitation services or a loss of earning power evaluation the services or evaluation shall only be provided by a vocational rehabilitation service provider who has been certified by the court.

B. No vocational rehabilitation service provider shall be deemed qualified unless he or she has satisfied the standards for certification established by the court and has been certified by the court.

C. The court will certify vocational rehabilitation service providers in the following areas: vocational rehabilitation counselor and job placement specialist.

D. A vocational rehabilitation counselor or job placement specialist employed by a state agency providing vocational rehabilitation services and not working as a private vocational rehabilitation service provider shall be exempt from meeting individual certification or renewal of certification requirements for so long as he or she remains employed by such agency and shall be considered qualified and certified to provide vocational rehabilitation services.

E. Certification may be denied, *suspended*, *revoked* , or placed in a *probationary status* if the court determines that the provider is not capable of rendering competent vocational rehabilitation services or for any of the following reasons:

1. Failure to comply with the ethical standards and responsibilities established by the court or the generally accepted standards of conduct in the vocational rehabilitation profession.
2. Conviction of a crime that is reasonably related to professional activities performed in providing vocational rehabilitation services.
3. Deliberately withholding pertinent information or submitting false or misleading information to any of the parties, another vocational rehabilitation service provider, or the court.
4. Failure to provide sufficient supporting documentation or deliberately presenting false or misleading information or omitting relevant facts in the application for certification under Rules 40 and 41.
5. Failure to comply with the reporting or notification requirements of Rule 37.
6. Failure to comply with the requirements of the Nebraska Workers' Compensation Act or the court's Rules of Procedure.

F. Certification of a vocational rehabilitation service provider shall not be denied, *suspended*, *revoked*, or placed in a *probationary status* pursuant to Rules 37, 39, 40, or 41 until after he or she has had notice and an opportunity to be heard by a judge of the court. A request by a vocational rehabilitation service provider to be heard by a judge of the court shall not stay operation of the denial, suspension, revocation, or probationary status unless such a stay is ordered by the judge.

Sections 48-162.01, 48-163, R.S. Supp., 2002.
Effective date December 19, 2000.

RULE 40

VOCATIONAL REHABILITATION
CERTIFICATION OF COUNSELORS

Words in italics are defined in Rule 49.

A. The vocational rehabilitation counselor certification process is designed to ensure individuals working in this specialized area of rehabilitation have attained an acceptable level of education, knowledge, and experience necessary to provide all relevant vocational rehabilitation services to the em-

ployee, and are otherwise capable of rendering competent vocational rehabilitation services to the employee.

B. For the purpose of the Nebraska Workers' Compensation Act, the vocational rehabilitation counselor, to be eligible for certification, shall meet the required education and/or employment experience. All education and/or experience claimed and used as a basis for certification shall have been attained at the time of application.

1. Acceptable employment experience shall be full-time paid employment as a vocational rehabilitation counselor.
2. Internships, preceptorships, or practica professionally supervised by a vocational rehabilitation counselor—whether paid or unpaid—or acceptable work related experience performed in a professional clinical/agency setting with a state agency providing vocational rehabilitation services, in private practice, or with a private rehabilitation firm may be counted toward meeting the full-time employment experience requirement.
3. Volunteer work experience activities may not be counted toward meeting the full-time employment experience requirement.

C. Certification shall be for a period of two years, except that certification may be extended for up to 90 days on a *probationary status* at the discretion of the court. To be eligible for certification, the applicant shall present documentary evidence that he/she has attained:

1. A master's or doctoral degree in rehabilitation counseling or rehabilitation administration from an accredited college or university, or;
2. A master's or doctoral degree in a counseling discipline from an accredited college or university, and six months experience as a vocational rehabilitation counselor, or;
3. A master's or doctoral degree in a human services field and 12 months acceptable employment experience as a vocational rehabilitation counselor, or;
4. Designation of Certified Rehabilitation Counselor (CRC) from the Certification of Rehabilitation Counselor Commission (CRCC), or;
5. Designation of Vocational Expert from the American Board of Vocational Experts (ABVE), or;
6. Designation of Certified Vocational Evaluator (CVE) from the Commission on the Certification of Work Adjustment and Vocational Evalu-

ation Specialists (CCWAVES), and 12 months acceptable employment experience as a vocational rehabilitation counselor, or;

7. A bachelor's degree in a human services related field and at least 30 months acceptable employment experience as a vocational rehabilitation counselor, or;
8. A bachelor's degree in any field (other than human services) and at least 36 months acceptable employment experience as a vocational rehabilitation counselor, and completion of at least nine credit hours of training or course work from an accredited college or university or an equivalent number of contact hours of CCMC/ CDMSC/ CRCC/ CCWAVES/ IARPS/ NBCC approved continuing education units in any of the following subject areas:
    a. Medical (and/or psychological) aspects of disability;
    b. Counseling theories;
    c. Individual/Group appraisal;
    d. Evaluation techniques in rehabilitation;
    e. Career information;
    f. Placement process in rehabilitation;
    g. Utilization of community resources;
    h. Survey of rehabilitation;
    I. Loss of earning power evaluations;
    j. Labor market survey techniques;
    k. Supervised practicum in rehabilitation.

D. An individual desiring certification as a vocational rehabilitation counselor shall submit to the court:

1. A completed application for certification. A form developed by the court shall be used for this purpose.
2. An official college transcript and, if applicable, proof of professional licensure and/or national certification.
3. A detailed employment history including at a minimum: names, addresses, and telephone numbers of the applicant's employers and immediate supervisors; inclusive dates of employment; and copies of official job descriptions or detailed summaries of job responsibilities for positions intended to meet the required employment experience.

4. Any other information, including supporting documentation, as requested by the court.

E. Individuals shall apply for renewal of certification within 60 days prior to the expiration date of their current certification period. If the renewal requirements as provided in Rule 40,F are not satisfied by the expiration date, the individual shall be notified that his or her certification has not been renewed or, where applicable, that certification has been extended on a *probationary status*. If certification is not renewed, either at the normal expiration date or following *probationary status*, the individual's name shall be removed from the directory of certified vocational rehabilitation counselors maintained by the court, and the counselor shall provide no further services in cases subject to the Act. The counselor shall notify the court of all employees for whom services are currently being provided, and a new counselor will be agreed to or appointed pursuant to Rule 42.

F. An individual desiring renewal of certification as vocational rehabilitation counselor shall submit to the court:

1. A completed application for certification. A form developed by the court shall be used for this purpose.
2. Documentary evidence that he or she has provided direct client case services during the previous 12-month period.
3. Documentary evidence that he or she has completed 24 contact hours of continuing education approved by CCMC/ CDMSC/ CRCC/ CCWAVES/ IARPS/ NBCC or the court's vocational rehabilitation section. The dates of completion of continuing education hours must fall within the current certification period.
4. Any other information, including supporting documentation, as requested by the court.

G. A counselor whose certification has not been renewed shall reapply for certification in order to provide services under the Act. No such application will be accepted for 90 days from the date of nonrenewal. In order to be eligible for certification after nonrenewal the applicant shall submit to the court:

1. A completed application for certification. A form developed by the court shall be used for this purpose.
2. Documentary evidence that he or she has provided direct client services during the past 12-month period.

3. Documentary evidence that he or she has completed at least 24 contact hours of continuing education approved by CCMC/ CDMSC/ CRCC/ CCWAVES/ IARPS/ NBCC or the court's vocational rehabilitation section. The dates of completion of continuing education hours must fall within the 24 months immediately preceding the application for certification.
4. Any other information, including supporting documentation, as requested by the court.

H. Failure to provide sufficient supporting documentation or deliberately presenting false or misleading information or omitting relevant facts in the application may cause certification to be denied, *suspended*, *revoked*, or placed in *probationary status*.

Section 48-165, R.R.S. 1998, and sections 48-162.01, 48-163, R.S. Supp., 2002.
Effective date December 17, 2002.

RULE 41

VOCATIONAL REHABILITATION CERTIFICATION OF JOB PLACEMENT SPECIALISTS

Words in italics are defined in Rule 49.

A. The job placement specialist, under the supervision of the vocational rehabilitation counselor, shall be responsible for assisting the employee in returning to gainful employment within the individual's capabilities. In conjunction with the vocational rehabilitation counselor, the job placement specialist shall confirm the employee's job readiness and overall preparation to seek employment.

1. The job placement specialist shall work closely with the employee to identify appropriate potential positions and/or vacancies for which the individual should apply. These positions shall be consistent with the employee's skills, interests, aptitudes, physical limitations and restrictions, and the specific vocational goal(s) listed on the approved vocational rehabilitation plan written by a vocational rehabilitation counselor.

2. The job placement specialist certification process is designed to ensure individuals working in this specialized area of rehabilitation have attained an acceptable level of education and experience necessary to provide all relevant services to the employee, and are otherwise capable of rendering competent job placement services to the employee.

B. A vocational rehabilitation counselor or job placement specialist employed by a state agency providing vocational rehabilitation services and not working as a private vocational rehabilitation service provider shall be exempt from meeting job placement specialist certification or renewal of certification requirements for so long as he or she remains employed by such agency and shall be considered qualified and certified to provide job placement services.

C. To be eligible for job placement specialist certification, the applicant shall meet the required education and/or employment experience. All education and/or experience claimed and used as a basis for certification shall have been attained at the time of application.

1. Acceptable job placement experience shall be full-time paid employment.
2. Supervised job placement internships, preceptorships, or practica—whether paid or unpaid—may be counted toward meeting the full-time employment experience requirement.
3. Volunteer work experience activities may not be counted toward meeting the full-time employment experience requirement.

D. Certification shall be for a period of two years, except that certification may be extended for up to 90 days on a *probationary status* at the discretion of the court. To be eligible for certification, the applicant shall present documentary evidence that he/she has attained:

1. A master's degree or higher in rehabilitation placement/job development from an accredited postsecondary institution, or;
2. A master's degree or higher in a counseling discipline from an accredited college or university, or;
3. Designation of Certified Rehabilitation Counselor (CRC) from the Certification of Rehabilitation Counselor Commission, or; Rehabilitation Counselor Commission (CRCC), or;
4. Designation of Vocational Expert from the American Board of Vocational Experts (ABVE), or;

5. Designation of Certified Vocational Evaluator (CVE) from the Commission on the Certification of Work Adjustment and Vocational Evaluation Specialists (CCWAVES), and 12 months acceptable employment experience as a vocational rehabilitation counselor, or;
6. Designation of Certified Case Manager (CCM) by the Certification of Insurance Rehabilitation Specialists Commission for Case Manager Certification (CCMC) and six months full-time, job placement related experience, or;
7. Designation of Certified Disability Management Specialist (CDMS) by the Certification of Disability Management Specialists Commission (CDMSC) and six months full-time, job placement related experience, or;
8. A bachelor's degree in rehabilitation placement/job development from an accredited postsecondary institution and six months full-time, job placement employment experience, or;
9. An associate degree or higher (in a field other than rehabilitation placement/job development, or counseling) from an accredited postsecondary institution, and 12 months full-time, job placement related experience, or;
10. A minimum of 36 months full-time job placement related experience.

E. An individual desiring certification as a job placement specialist shall submit to the court:

1. A completed application for certification. A form developed by the court shall be used for this purpose.
2. An official transcript from the postsecondary institution and, if applicable, proof of professional licensure and/or national certification.
3. A detailed employment history including at a minimum: names, addresses, and telephone numbers of the applicant's employers and immediate supervisors; inclusive dates of employment; and copies of official job descriptions or detailed summaries of job responsibilities for positions intended to meet the required employment experience.
4. Any other information, including supporting documentation, as requested by the court.

F. Individuals shall apply for renewal of certification within 60 days prior to the expiration date of their current certification period. If the renewal requirements as provided in Rule 41,F are not satisfied by the expiration

date, the individual shall be notified that his or her certification has not been renewed or, where applicable, that certification has been extended on a *probationary status*. If certification is not renewed, either at the normal expiration date or following *probationary status*, the individual's name shall be removed from the directory of certified job placement specialists maintained by the court, and the job placement specialist shall provide no further services in cases subject to the Nebraska Workers' Compensation Act. The job placement specialist shall notify the court of all employees for whom services are currently being provided.

G. An individual desiring renewal of certification as a job placement specialist shall submit to the court:

1. A completed application for certification. A form developed by the court shall be used for this purpose.
2. Documentary evidence that he or she has provided direct job placement services during the previous 12-month period.
3. Documentary evidence that he or she has completed at least 24 contact hours of continuing education approved by CCMC/ CDMSC/ CRCC/ CCWAVES/ IARPS/ NBCC or the court's vocational rehabilitation section. The dates of completion of continuing education hours must fall within the current certification period.
4. Any other information, including supporting documentation, as requested by the court.

H. A job placement specialist whose certification has not been renewed shall reapply for certification in order to provide services under the Act. No such application will be accepted for 90 days from the date of nonrenewal. In order to be eligible for certification after nonrenewal the applicant shall submit to the court:

1. A completed application for certification. A form developed by the court shall be used for this purpose.
2. Documentary evidence that he or she has provided direct client services during the past 12-month period.
3. Documentary evidence that he or she has completed at least 24 contact hours of continuing education approved by CCMC/ CDMSC/ CRCC/ CCWAVES/ IARPS/ NBCC or the court's vocational rehabilitation section. The dates of completion of continuing education hours must fall within the 24 months immediately preceding the application for certification.

4. Any other information, including supporting documentation, as requested by the court.

I. Failure to provide sufficient supporting documentation or deliberately presenting false or misleading information or omitting relevant facts in the application may cause certification to be denied, *suspended*, *revoked*, or placed in *probationary status*.

Section 48-165, R.R.S. 1998, and sections 48-162.01, 48-163, R.S. Supp., 2002.
Effective date December 17, 2002.

RULE 42

CHOICE OF VOCATIONAL REHABILITATION COUNSELOR

A. If entitlement to vocational rehabilitation services is claimed by the employee, or a loss of earning power evaluation is desired by any party, the selection requirements of section 48-162.01(3) shall apply. The parties shall make a good faith attempt to agree on the choice of a vocational rehabilitation counselor from the directory of vocational rehabilitation counselors.

1. Any party may propose the selection of a vocational rehabilitation counselor from the directory.
2. The proposed vocational rehabilitation counselor shall obtain written agreement of his or her selection from the other party or parties. The vocational rehabilitation counselor may contact the parties directly for this purpose. If agreement is obtained, the vocational rehabilitation counselor shall notify the court of his or her selection pursuant to Rule 37.

   Before the selection is made, the vocational rehabilitation counselor must provide written notice to the employee of his or her rights regarding the selection of the vocational rehabilitation counselor. The written notice shall include:

   a. The employee's right to agree to the proposed vocational rehabilitation counselor to provide vocational rehabilitation services;

   b. The employee's right not to agree to the proposed vocational rehabilitation counselor;

c. The employee's right to propose a vocational rehabilitation counselor of his or her own choosing;

d. That if the parties are unable to agree on a vocational rehabilitation counselor, the employee may request the court to appoint a vocational rehabilitation counselor at no cost to the employee.

A form developed by the court may be used to provide the required notice to the employee.

3. If, after a good faith attempt, the parties are unable to agree on the selection of a vocational rehabilitation counselor, a party shall notify the court, in writing, of the disagreement and shall request that the court appoint a vocational rehabilitation counselor from the directory. This request shall be made using a form approved by the court with the requestor providing copies to all other parties.

4. Within fifteen working days following notification that the parties are unable to agree to the selection of a vocational rehabilitation counselor, a rehabilitation specialist of the court shall select a vocational rehabilitation counselor from the directory and advise the parties of the name of the court appointed vocational rehabilitation counselor.

5. Once the vocational rehabilitation counselor has been appointed by the court, the counselor shall contact all the parties in accordance with Rule 42,C,3 to determine the specific agreed upon services to be provided. Written confirmation of such agreement shall be obtained by the counselor from each of the parties. Services shall be limited to those agreed upon and confirmed in writing by the parties or ordered by the court.

B. When assigning a vocational rehabilitation counselor, a rehabilitation specialist of the court shall contact the individual whose name appears at the top or first position of the directory to ascertain if that vocational rehabilitation counselor agrees to accept the assignment, taking into consideration, but not limited to, such factors as timeliness, type of disability, or geographic location.

1. If the vocational rehabilitation counselor accepts the assignment, his or her name shall be placed at the end of the directory. The next vocational rehabilitation counselor's name on the directory shall then be moved to the top of the directory.

2. In the event that the vocational rehabilitation counselor is unable or elects not to accept the assignment, the vocational rehabilitation counselor whose name appears next on the directory shall be contacted to determine if he or

she will accept the assignment. This process shall continue until the appointment is finally accepted.

3. Three consecutive refusals or declinations without good cause to accept an assignment shall result in the vocational rehabilitation counselor's name being placed at the end of the directory.

C. All contact between the vocational rehabilitation counselor and the parties, other than the employee, shall be in writing with copies provided to all other parties, with an additional copy sent directly to the employee, except that the vocational rehabilitation counselor may have direct contact:

1. As provided in Rule 42,A.2;
2. With the employer to assess the likelihood of the employee being able to return to the previous job with the same employer, or being able to return to the previous job with modifications, or to obtain a new job with the same employer. For purposes of this paragraph "employer" shall not include attorneys, claims representatives, risk management personnel, or similar representatives of the employer, but shall only include that person or persons required to explain what the applicable job entails, and what may be necessary to modify the job;
3. With all parties when they agree to jointly meet or to conduct a jointly held conference call with the vocational rehabilitation counselor to discuss the case;
4. For the purpose of taking a deposition;
5. With the employer or his or her insurer to assist the employee in obtaining special or adaptive equipment necessary for the employee to accomplish an approved vocational rehabilitation plan, or necessary for the purposes delineated in Rule 42,C,2;
6. With the employer or his or her insurer to assist the employee in determining the status of temporary disability benefit payments while undergoing an approved vocational rehabilitation plan;
7. With the employer or his or her insurer to assist the employee in arranging for necessary specialized or acute medical care while the employee is participating in an approved vocational rehabilitation plan.

D. The vocational rehabilitation counselor chosen or selected pursuant to this rule shall be the sole vocational rehabilitation counselor to provide vocational rehabilitation services or to perform a loss of earning power evaluation at any one time.

E. If an employer received notice of injury before January 1, 1994, the employee may continue to receive vocational rehabilitation services from the vocational rehabilitation counselor selected prior to that date. Any change of vocational rehabilitation counselor requested on or after January 1, 1994 shall be pursuant to Rule 43.

F. The parties, other than the employee, shall not attempt to influence or to control the meeting place, the outcome of the evaluation, or the recommendations of the vocational rehabilitation counselor. The meetings shall be held at a neutral site, except as provided in Rule 42,C.

Sections 48-162.01, 48-163, R.S. Supp., 2002.
Effective date October 27, 1998.

RULE 43

CHANGE OF VOCATIONAL REHABILITATION COUNSELOR

A. While either party may retain a vocational rehabilitation counselor for rebuttal purposes at its own expense, only one vocational rehabilitation counselor may provide vocational rehabilitation services or perform a loss of earning power evaluation at any one time.

B. A change in the vocational rehabilitation counselor providing vocational rehabilitation services to or performing a loss of earning power evaluation on an employee may be requested by the employee or the employer or his or her insurer. This change shall only be made after approval has been obtained from the court.

1. The party desiring a change in vocational rehabilitation counselor must submit the request in writing to the court, using a form approved by the court with copies to all other parties.
2. The request shall identify the names and addresses of the current and proposed vocational rehabilitation counselor, if known, and the specific reasons for the requested change.
3. A rehabilitation specialist of the court will review the request and either approve or deny the request within fifteen working days.
    a. If the rehabilitation specialist of the court does not concur with the requested change, the rehabilitation specialist will notify all parties of

the denial and the reasons for rejecting the requested change. When a change request is not approved, vocational rehabilitation services must be continued with the previously agreed upon or appointed vocational rehabilitation counselor.

b. If the rehabilitation specialist of the court determines that a change in vocational rehabilitation counselor should be approved, the rehabilitation specialist will notify the employee, the employer or his or her insurer, and the current counselor of that decision.

4. If, within 30 days of notification that the request for change in vocational rehabilitation counselor has been approved, both parties are unable to agree on a new vocational rehabilitation counselor, the employee or employer or his or her insurer must notify the court, and a rehabilitation specialist of the court will select the new counselor from the directory in accordance with Rule 42,B.

5. If, after 30 days of notification that the request for change in vocational rehabilitation counselor has been approved, the court has not been notified of the selection of a new vocational rehabilitation counselor or that both parties are unable to agree on the selection of a new vocational rehabilitation counselor, the rehabilitation specialist of the court may either appoint the vocational rehabilitation counselor initially proposed by the party requesting the change or appoint a vocational rehabilitation counselor from the directory in accordance with Rule 42,B. The rehabilitation specialist of the court will then notify the employee, the employer or his or her insurer, and the new counselor of the appointment.

C. Once a change of vocational rehabilitation counselor has been accomplished, the previous vocational rehabilitation counselor shall provide any and all pertinent information in the previous vocational rehabilitation counselor's possession to the newly appointed vocational rehabilitation counselor except for such information that may be legally considered proprietary in nature.

D. Once a change of vocational rehabilitation counselor has been accomplished, the newly appointed vocational rehabilitation counselor shall contact all the parties in accordance with Rule 42,C,3 to determine the specific agreed upon services to be provided. Written confirmation of such agreement shall be obtained by the counselor from each of the parties. Services shall be limited to those agreed upon and confirmed in writing by the parties or ordered by the court.

Sections 48-162.01, 48-163, R.S. Supp., 2002.
Effective date April 25, 2002.

RULE 44

VOCATIONAL REHABILITATION PLAN DEVELOPMENT AND IMPLEMENTATION

A. The vocational rehabilitation counselor voluntarily chosen or appointed shall perform the unbiased and accurate evaluation, development, submission, and implementation of the employee's vocational rehabilitation plan.

1. When required, the vocational rehabilitation counselor shall evaluate the employee's vocational interests, aptitudes, skills, and physical, psychological, and psychosocial abilities. In addition to reviewing medical data or consulting with medical and/or mental health professionals, the vocational rehabilitation counselor may obtain the data via interviews, review of medical, diagnostic, psychometric, and related information describing the individual's injury and functional capabilities.
2. When required, the vocational rehabilitation counselor or other qualified personnel under the supervision of the vocational rehabilitation counselor shall perform transferable skills analyses, labor market surveys, utilization of occupational and employment information, and on-the-job evaluations (including real or simulated work activity determinations), administering and/or interpreting psychometric and/or vocational testing (to include standardized interest, aptitude, achievement, and specific skills tests).

B. The vocational rehabilitation counselor voluntarily chosen or appointed shall evaluate the employee to determine what vocational rehabilitation services, if any, may be needed to assist the employee to return to suitable employment.

1. The vocational rehabilitation counselor shall follow the priorities pursuant to section 48-162.01 in evaluating the employee and developing a rehabilitation plan. No formal retraining plan shall be submitted to the court unless the vocational rehabilitation counselor certifies that all lower priorities have been determined to be unlikely to result in a suitable job placement or return to work opportunity for the injured employee.
2. No higher priority may be utilized unless the vocational rehabilitation counselor has determined that all lower priorities would unlikely result in the job placement or return to work of the injured employee. If a lower priority is clearly inappropriate for the employee, the next higher priority shall be utilized.
3. The following priorities are listed in order from lower to higher priority.

a. Return to the previous job with the same employer;

b. Modification of the previous job with the same employer;

c. A new job with the same employer;

d. A job with a new employer;

e. A period of formal retraining which is designed to lead to employment in another career field. This is designed to prepare the employee for suitable employment in another occupation. Formal retraining shall be applicable to the specific vocational goal listed on the proposed vocational rehabilitation plan and shall be appropriate and necessary to enable the employee to obtain employment in the proposed occupation.

C. Only certified vocational rehabilitation counselors shall develop vocational rehabilitation plans. When the vocational rehabilitation counselor determines the injured employee will be unable to return to suitable employment without the provision of vocational rehabilitation services, the vocational rehabilitation counselor shall develop a vocational rehabilitation plan and submit it directly to the court. The plan shall list the specific vocational goal, the specific types of services and estimated costs necessary to meet the specific vocational goal.

D. All proposed rehabilitation plans and amendments shall be submitted on a vocational rehabilitation plan form developed by the court. Copies of all psychometric testing results, including but not limited to academic, achievement, vocational, and interest tests, and vocational evaluation summaries shall be provided with the vocational rehabilitation plan when submitted to the court. Vocational rehabilitation counselors shall provide detailed justification for all training, services and related costs listed on the vocational rehabilitation plan.

E. The fee of the vocational rehabilitation counselor for the evaluation and for the development and implementation of the vocational rehabilitation plan shall be paid for by the employer or his or her insurer. Such fee shall include expenses for job placement services provided by the vocational rehabilitation counselor as well as expenses for a certified job placement specialist or an interpreter when necessary to assist the vocational rehabilitation counselor in the performance of his or her duties. Any such job placement specialist or interpreter shall be selected by the vocational rehabilitation counselor.

Section 48-165, R.R.S. 1998, and sections 48-162.01, 48-163, R.S. Supp., 2002. Effective date October 27, 1998.

RULE 45

LOSS OF EARNING POWER EVALUATION

A. Loss of earning power evaluations shall be performed by private vocational rehabilitation counselors whose names appear on the approved directory established by the court.

B. If the parties cannot agree on the choice of a vocational rehabilitation counselor from the directory to perform the loss of earning power evaluation, the parties shall request the court to assign a vocational rehabilitation counselor from the directory of vocational rehabilitation counselors pursuant to the procedures outlined in Rule 42.

C. The fee of the vocational rehabilitation counselor for the loss of earning power evaluation shall be paid by the employer or his or her insurer. Such fee shall include expenses for an interpreter when necessary to assist the vocational rehabilitation counselor in the performance of his or her duties. Any such interpreter shall be selected by the vocational rehabilitation counselor.

Sections 48-162.01, 48-163, R.S. Supp., 2002.
Effective date October 27, 1998.

RULE 46

SETTLEMENT AGREEMENTS

A. Before any application for an order approving a settlement agreement affecting a claim for workers' compensation is approved or otherwise acted upon by this court, the original and a duplicate original of such application both signed and verified by all parties, must first be filed with the compensation court and entered of record by the clerk thereof.

1. Each time that an application for an order approving a settlement agreement is submitted or resubmitted after being withdrawn or disapproved, it must be accompanied by the statutory filing fee of $15.00.
2. There must be on file or there shall be filed with the application a first report of alleged occupational injury or illness, in a form prescribed by the court.
3. If any such application for an order approving settlement agreement is designed to fix the duration of disability, or to fix the extent of perma-

nent disability, then in any such case at least one medical report by an attending or examining physician shall accompany the application. Copies of all medical reports to be submitted with the application shall be provided to the claimant prior to claimant's signing and verifying the application.

4. Sufficient evidence must be submitted with the application for approval of settlement agreement to establish that the settlement is for the best interests of the claimant and that the application is in conformity with the workers' compensation schedule and law.
5. An application will not be considered for approval without an original and one copy of a proposed order of approval.

B. The following information shall be included in or submitted with the application for an order approving settlement agreement.

1. The application is to be venued "In The Nebraska Workers' Compensation Court" and the title must clearly identify it as an application for approval of settlement agreement.
2. The salary paid, and whether it is on an hourly, daily, weekly, monthly, or other basis must be shown.
3. The number of weeks and dates of temporary total and temporary partial disability sustained and the number of weeks which have been paid and or are being paid under the settlement must be clearly stated.
4. The percentage of permanent impairment and or loss of earning power sustained, the number of weeks paid and to be paid and the amount of compensation per week must be clearly stated.
5. An itemized list of all medical, hospital and miscellaneous expenses incurred and whether paid or to be paid and by whom paid or to be paid must be clearly stated. Any payments which have been reduced by operation of the court's Schedule of Medical and Hospital Fees must be clearly identified.
6. In those cases in which there is subrogation, the full liability under the compensation law and the amount being subrogated must be set out. In addition, the extent of each party's participation in achieving any third party recovery must be set forth.
7. The computation must always be shown on the application.
8. The application must state whether or not the claimant has returned to work and if so, the date, the type of work, and wage.

9. In every case there must be a statement in the application that the claimant understands his or her rights regarding vocational rehabilitation. Attempts to "buy out" vocational rehabilitation will not be approved.

10. The social security account number of the claimant must be included.

C. If the court requests additional information from the parties prior to the approval of the application for approval of settlement agreement, the deadline for submission of the information shall be ten calendar days from the date of the court's request. An extension of up to seven days may be granted upon good cause shown, if either party, on their own initiative, contacts the court to request the extension. At the expiration of the ten day deadline or a court granted extension, an Order of Disapproval shall be entered if the requested information has not been submitted.

D. After approval in compensation court and payment of the settlement has been made, the employer, insurer, or risk management pool must file with the compensation court a Subsequent Report (Form 4) showing all amounts paid in the case, in the form prescribed by the court. The Form 4 must be filed promptly, but in no event later than fourteen days following payment.

E. Sums being paid under the settlement agreement are to be paid directly to those entitled to said sums, not into court. Payment must be made within thirty days after approval in compensation court.

F. Compromise settlements will not be approved unless there is evidence submitted with the application which satisfies the court that the matter is doubtful and disputed. All requirements of the compensation court must be satisfied before any application will be approved.

G. A hearing will be scheduled when the court, in its discretion, deems it necessary.

H. For cases in which the employer has continued to pay full salary, credit will be allowed only for that portion of the full salary payment that was intended to apply to workers' compensation benefits, not to exceed the weekly income benefit owed pursuant to the Nebraska Workers' Compensation Act.

I. An application for approval of settlement agreement will not be approved if there is any statement or implication that such settlement agreement is final or which requires a release from the claimant.

Sections 48-136, 48-138, 48-144, 48-165, R.R.S. 1998, and sections 48-139, 48-163, R.S. Supp., 2002.
Effective date December 17, 2002.

RULE 47

LUMP SUM SETTLEMENT

A. Before any application for an order approving a lump sum settlement in a compensation case shall be approved or otherwise acted upon by this court, the original and a duplicate original of such application, both signed and verified by all parties, must first be filed with the compensation court and entered of record by the clerk thereof.

1. Each time that an application for an order approving a lump sum settlement is submitted or resubmitted after being withdrawn or disapproved, it must be accompanied by the statutory filing fee of $15.00.
2. At least one medical report by an attending or examining physician, substantiating the disability for which compensation is to be paid, shall accompany the application for approval. Copies of all medical reports to be submitted with the application shall be provided to the claimant prior to claimant's signing and verifying the application.
3. Sufficient evidence must be submitted with the application to establish that the settlement is for the best interests of the claimant and that the application is in conformity with the workers' compensation schedule and law.
4. An application will not be considered for approval without an original and one copy of a proposed order of approval. A standard order developed by the court shall be used for this purpose.

B. The following information shall be included in or submitted with the application for an order approving lump sum settlement. A standard form or forms developed by the court may be used to meet these requirements.

1. The application is to be venued "In The Nebraska Workers' Compensation Court" and the title must clearly identify it as an application for approval of lump sum settlement.
2. The salary paid, and whether it is on an hourly, daily, weekly, monthly, or other basis must be shown.
3. The number of weeks and dates of temporary total and temporary partial disability sustained and the number of weeks which have been paid and/or are being paid under the settlement must be clearly stated.
4. The percentage of permanent impairment and/or loss of earning power sustained, the number of weeks paid and to be paid and the amount of compensation per week must be clearly stated.

5. An itemized list of all medical, hospital and miscellaneous expenses incurred and whether paid or to be paid and by whom paid or to be paid must be clearly stated. Any payments which have been reduced by operation of the court's Schedule of Medical and Hospital Fees must be clearly identified. If the application provides for payment of future medical expenses incurred by the employee, there must be a statement in the application that in the event that a dispute arises as to payment of a medical expense, the parties may submit the matter to a judge of the compensation court for a determination.
6. In those cases in which there is subrogation, the full liability under the compensation law and the amount being subrogated must be set out. In addition, the extent of each party's participation in achieving any third party recovery must be set forth.
7. The computation must always be shown on the application.
8. The application must state whether or not the claimant has returned to work and if so, the date, the type of work, and wage.
9. In every case there must be a statement in the application that the claimant understands his or her rights regarding vocational rehabilitation, and there must be a waiver by the claimant of any further rights to vocational rehabilitation benefits. This is required even if the claimant has returned to work. The reason for the waiver must be given. Waivers will be closely scrutinized by the court, and in most cases will not be approved if the claimant has not returned to suitable employment. Attempts to "buy out" vocational rehabilitation will not be approved.
10. When an annuity or structured settlement is used to effectuate a lump sum settlement, the terms of said annuity or structured settlement together with the name of the annuity carrier must be included in the application, although the cost of the annuity or structured settlement need not be set forth; however, the cost of any annuity must be separately provided in writing to the court with the submission of the application. Any such application shall recite that the workers' compensation insurer, risk management pool, or self-insured employer shall be responsible for all payments in the application in case the annuity carrier or any entity to which the annuity has been assigned is unable to fulfill any of its obligations. The application shall also state that the owner of the annuity or structured settlement shall be someone other than the employee or other beneficiary, and that the employee or other beneficiary shall have no control over or right to transfer the annuity or structured settlement.

11. The social security account number of the claimant must be included.

C. If the court requests additional information from the parties prior to the approval of the application, the deadline for submission of the information shall be ten calendar days from the date of the court's request. An extension of up to seven days may be granted upon good cause shown, if either party, on their own initiative, contacts the court to request the extension. At the expiration of the ten day deadline or a court granted extension, an Order of Disapproval shall be entered if the requested information has not been submitted.

D. After approval in compensation court and payment of the settlement has been made, the employer, insurer, or risk management pool must file with the compensation court a Subsequent Report (Form 4) showing all amounts paid in the case, in the form prescribed by the court. The Form 4 must be filed promptly, but in no event later than fourteen days following payment.

E. Sums being paid under the lump sum settlement are to be paid directly to those entitled to said sums, not into court. Payment must be made within thirty days after approval in compensation court.

F. Compromise settlements will not be approved unless there is evidence submitted with the application which satisfies the court that the matter is doubtful and disputed. A lump sum settlement will not be approved if all of the compensation payable under such settlement is due and no reasonable controversy exists, unless a reasonable additional amount is paid as consideration for such lump sum settlement. All requirements of the compensation court must be satisfied before any lump sum settlement will be approved.

G. A hearing will be scheduled when the court, in its discretion, deems it necessary.

H. For cases involving life expectancies the U.S. Life Table, 1999, shall be the minimum life expectancy table used. A copy of this table may be found in the addenda to these rules.

I. For cases in which the employer has continued to pay full salary, credit will be allowed only for that portion of the full salary payment that was intended to apply to workers' compensation benefits, not to exceed the weekly income benefit owed pursuant to the Nebraska Workers' Compensation Act.

Sections 48-138, 48-144, 48-165, R.R.S. 1998, and sections 48-139, 48-163, R.S. Supp., 2002.
Effective date December 17, 2002.

RULE 48

INFORMAL DISPUTE RESOLUTION

A. Resolution of any workers' compensation dispute or controversy is available on an informal basis. Any party may contact the court to request resolution by informal means, or a judge of the court may, on his or her own motion, refer the parties to informal dispute resolution.

B. Any dispute regarding medical, surgical, or hospital services furnished or to be furnished under section 48-120 may be submitted by the supplier of such services.

1. Such dispute may include the reasonableness and necessity of any medical treatment provided or to be provided to the injured employee.
2. Such dispute may include the application of the medical and hospital fee schedules or payment for services rendered by an independent medical examiner.

C. Before any dispute involving medical treatment or medical issues related to managed care may be submitted to the court for informal dispute resolution the internal dispute resolution procedure of the managed care plan shall first be exhausted.

D. Any dispute regarding a requested change of physician shall be submitted for resolution by informal means.

E. The court shall identify all parties to the dispute and notify all parties of the proposed informal means of resolving the dispute. The court staff shall by informal means, which may include telephone contact, determine the nature and extent of the dispute or controversy and attempt to resolve it. The court staff may request the parties to identify, in writing, the issues that are disputed and to be submitted for resolution by informal means. The court staff may require that the parties or others appear and submit relevant information. At the conclusion of the informal resolution process, a written statement shall be issued to all parties by the court that documents the results of informal resolution process.

1. Any party who requests such informal dispute resolution shall not be precluded from filing a petition pursuant to section 48-173.
2. Any settlement or agreement reached as the result of informal dispute resolution shall be final and binding only if the settlement or agreement is in conformity with the Nebraska Workers' Compensation Act.

F. The following principles apply to all informal means employed by the court to resolve disputes or controversies.

1. All informal proceedings are regarded as settlement negotiations and no admission, representation, or statement made in the proceedings, not otherwise discoverable or obtainable, shall be admissible as evidence or subject to discovery.
2. Any court staff shall not be subject to process requiring the disclosure of any matter discussed during informal dispute resolution proceedings.
3. Any information from the files, reports, notes of court staff or other materials or communications, oral or written, relating to an informal dispute resolution proceeding obtained by court staff is privileged and confidential and may not be disclosed without the written consent of all parties to the proceeding.
4. No court staff shall be held liable for civil damages for any statement or decision made in the process of informal dispute resolution unless such person acted in a manner exhibiting willful or wanton misconduct.

Section 48-168, R.R.S. 1998, and sections 48-120, 48-163, R.S. Supp., 2002.
Effective date December 19, 2000.

RULE 49

DEFINITIONS

The following words and terms, when used in the Rules of Procedure of the Nebraska Workers' Compensation Court shall have the following meanings, unless the context of the particular rule clearly indicates otherwise.

A. Compensability. "Compensability" or "compensable" when used with reference to injuries or diseases means personal injuries for which an employee is entitled to compensation from his or her employer pursuant to section 48-101.

B. Complex Case. "Complex case" when used with reference to fees for services performed by an independent medical examiner means a case requiring two or more of the following in order to render medical findings on the questions and issues submitted:

1. two or more hours of face-to-face time by the physician with the patient;
2. two or more hours of record review by the physician;
3. two or more hours of medical research by the physician;
4. addressing the issue of medical causation;
5. addressing the issue of apportionment between any preexisting impairment or disability and the impairment or disability contributed by the injury in question.

C. Denial of Compensability. "Denial of compensability" or "compensability is denied" means a denial that the employee is entitled to compensation for personal injury from his or her employer pursuant to section 48-101.

D. Emergency Medical Treatment. "Emergency medical treatment" means those medical services that are required for the immediate diagnosis and treatment of conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or that are immediately necessary to alleviate severe pain. "Emergency medical treatment" includes treatment delivered in response to symptoms that may or may not represent an actual emergency, but is necessary to determine whether an emergency exists.

E. Family Physician. "Family physician" when used with reference to an employee's right to choose a primary treating physician, means a physician who has maintained the medical records of and has a documented history of treatment with the employee or an employee's immediate family member prior to an injury.

F. Health Care Providers. "Health care providers" means providers or suppliers of health care services.

G. Health Care Services. "Health care services" means medical, surgical, or hospital services, including specialized medical services, for which the employer is liable pursuant to section 48-120.

H. Immediate Family Member. "Immediate family member" when used with reference to the selection of a physician pursuant to section 48-120(2)(a) means the employee's spouse, children, parents, stepchildren, and stepparents.

I. Independent Medical Examiner. "Independent Medical Examiner" means either a physician appointed and assigned by the court or a physician agreed

to by the parties pursuant to section 48-134.01. In either case the physician shall render medical findings on the medical condition of an employee and related issues pursuant to section 48-134.01.

J. Major Surgical Operation. "Major surgical operation" means any invasive procedure that requires the penetration of the body or removal of human tissues and requires the administration in any concentration of anesthesia or sedation which renders an individual incapable of taking action for self-preservation under emergency conditions without the assistance of another individual.

K. Managed Care Plan. "Managed care plan" means a plan certified by the court that provides for the delivery and management of treatment to injured employees.

L. Nonparticipating Physician. "Nonparticipating Physician" when used with reference to a managed care plan means a physician who is not a participating physician, but who may provide services pursuant to Rule 56 to an employee subject to a managed care plan contract.

M. Participating Physician. "Participating Physician" means a physician with which a managed care plan has a contract or other arrangement for the delivery of health care services to injured employees.

N. Participating Health Care Provider. "Participating health care provider" means any person or entity with which the managed care plan has a contract or other arrangement for the delivery of health care services to injured employees.

O. Physician. "Physician" means any person licensed to practice medicine and surgery, osteopathic medicine, chiropractic, podiatry, or dentistry in the State of Nebraska or in the state in which the physician is practicing.

P. Primary Treating Physician. "Primary treating physician" means a physician who is responsible for providing primary medical care to the employee, maintaining the continuity of the employee's medical care and initiating referrals to other health care providers.

Q. Probation. "Probation" or "probationary status" when used with reference to vocational rehabilitation means the limitation for a specified period of time and under such conditions as determined by the court of a vocational rehabilitation provider's certification to provide vocational rehabilitation services under Rules 37 through 44, or to perform a loss of earning power evaluation under Rule 45.

R. Revocation. "Revocation" or "revoked" when used with reference to vocational rehabilitation means the termination, prior to the normal expiration date, of a vocational rehabilitation provider's certification to provide vocational rehabilitation services under Rules 37 through 44, or to perform a loss of earning power evaluation under Rule 45. "Revocation" or "revoked" when used with reference to a managed care plan means the termination of a managed care plan's certification to provide services under Rules 51 through 61.

S. Specialized Medical Services. "Specialized medical services" means healthcare services other than those provided by a primary treating physician.

T. Suspension. "Suspension" or "suspended" when used with reference to vocational rehabilitation means the discontinuation for a specified period of time of a vocational rehabilitation provider's certification to provide vocational rehabilitation services under Rules 37 through 44, or to perform a loss of earning power evaluation under Rule 45. "Suspension" or "suspended" when used with reference to a managed care plan means that a managed care plan's authority to enter into new or amended contracts with insurers, risk management pools, or self insured employers has been suspended by the court for a period of time.

Sections 48-120, 48-120.02, 48-134.01, 48-163, R.S. Supp., 2002.
Effective date December 1, 1999.

RULE 50

CHOICE OF PHYSICIAN

Words in italics are defined in Rule 49.

A. Employee's Choice.

1. If the employer does not give the employee notice, as described in Rule 50,B,2, of the right to choose a *family physician* as the *primary treating physician,* the employee is free to choose any *physician* qualified to treat the injury as the *primary treating physician*.
2. If the employer gives the employee notice, as described in Rule 50,B,2, the employee has the right to choose a *family physician* as the *primary treating physician*. As soon as possible after getting the notice, the

employee must give the employer the name of the *family physician* chosen. The employee must do this before receiving any treatment, unless it is *emergency medical treatment*. If the employee does not do this, the employer has the right to choose the *primary treating physician*.

3. The employer may ask the *family physician* chosen by the employee for a letter to verify prior treatment. If an authorization is needed, the employee or *immediate family member* must give it. If it is not given, the employer has the right to choose the *primary treating physician*.
4. The employee may not change the *primary treating physician* chosen according to Rule 50,A,2 unless the employer agrees or the compensation court orders the change. A referral by the *primary treating physician* is not a change.
5. The employee may choose the *physician* to do surgery when the injury involves dismemberment or a *major surgical operation*.
6. The employee may choose a *physician* if *compensability is denied* and the employer will pay for medical, surgical, or hospital services later found to be *compensable*.
7. If the *primary treating physician* chosen by the employer refuses to provide certain medical services and those services are later ordered by the compensation court, the employee can choose a *physician* to furnish further services.

B. Employer's Choice.

1. The employer may have the right to choose an injured employee's *primary treating physician*. If the employer wishes to choose, the employer must first give the employee notice, following an injury, of the right to choose a *family physician* as the *primary treating physician.*
2. The court has a form the employer may use to give notice to the employee. In all cases, the notice:
   a. must be given to the employee as soon as possible after the employer knows about the injury;
   b. must tell the employee of the right to choose a *family physician* as the *primary treating physician*;
   c. must tell the employee to give the employer the name of the *family physician* chosen as the *primary treating physician* as soon as possible after getting notice from the employer, and before any treatment, unless it is *emergency medical treatment*;

d. must tell the employee the employer gets to choose the *primary treating physician* if the employer is not given the name of the *family physician* as soon as possible after the employee receives the notice;

e. must tell the employee the employer gets to choose the *primary treating physician* if an authorization is needed to verify prior treatment and is not given; and

f. must tell the employee the *primary treating physician* may not be changed once the employer has been given the name, unless the change is agreed to by the employer or is ordered by the compensation court. A referral by the *primary treating physician* is not a change.

3. The employer may ask the *family physician* for a letter to verify prior treatment. If an authorization is needed, the employee or *immediate family member* must give it.

4. The employer can choose the *primary treating physician* following notice to the employee if:

   a. the employee has no *family physician*; or

   b. there is a *family physician* but the employee does not tell the employer the name of the *family physician* as soon as possible after getting notice from the employer; or

   c. if authorization to verify treatment by the *family physician* is not given.

5. If the employee lives or works in a city of 5,000 or more, the *primary treating physician* chosen by the employer must be within 30 miles of where the employee lives or works. If the employee lives and works outside a city of 5,000 or more, the *physician* must be within 60 miles of where the employee lives or works. If there is no *physician* qualified to treat the injury within these mileage limits, they do not apply.

6. The employer may not change the choice of the *primary treating physician* made according to Rule 50,B,4, unless the employee agrees or the compensation court orders a change. A referral by the *primary treating physician* is not a change.

7. The employer does not have to give the employee notice of the right to choose a *family physician* as the *primary treating physician*. If the employer does not give notice, the employee is free to choose any *physician* qualified to treat the injury as the *primary treating physician*.

C. Change of *Physician*. Following notice as described in Rule 50,B,2 if the *primary treating physician* has been chosen by the employee according to Rule 50,A,2 or by the employer according to Rule 50, B,4, there can be no change in the *primary treating physician* unless the employee and employer agree or the compensation court orders a change. If the employee and employer cannot agree, a request for informal dispute resolution must be submitted in accordance with Rule 48.

D. Referrals. The *primary treating physician* may arrange for *specialized medical services* the employee needs. A referral by the *primary treating physician* is not a change. A *physician* may not send an employee to a facility in which the *physician* has an ownership or similar financial or investment interest, unless the services are not available within 60 miles of where the employee lives or works. The rules of the *managed care plan* will apply to referrals made by a *participating or nonparticipating physician* under a *managed care plan*.

E. Inability to Follow Rule 50 for Choice of *Primary Treating Physician*. An employer and/or employee may be unable to follow Rule 50 to choose the *primary treating physician*. This may happen if the injury takes place away from the employer's place of business or because of the type of injury. Rule 50 will not apply to choosing the *primary treating physician* as long as this inability lasts.

F. Travel Expenses. If the employee chooses a *physician* from a community other than where the employee lives or works, and if a *physician* is available in a closer community, the employer does not have to pay travel expenses.

G. Effective Date. If the employer received notice of the injury before January 1, 1994, the employee may continue to receive services for that injury from a *physician* selected prior to that date.

Sections 48-164, 48-165, 48-168, 48-173, R.R.S. 1998, and 48-120, 48-120.02, 48-163, R.S. Supp., 2002.
Effective date December 1, 1999.

RULE 51

MANAGED CARE
PURPOSE

A. The purpose of Rule 51 through Rule 61 is to establish procedures and requirements for certification of a managed care plan relating to the management and delivery of medical, surgical, and hospital services to injured employees under the Nebraska Workers' Compensation Act, and for contracting between a certified managed care plan and an insurer, risk management pool, or self insured employer.

B. No health care provider, network of providers, employer, insurer, risk management pool or any other person may make any representation or state in any name, contract, or literature that an entity constitutes workers' compensation managed care for the provision of services under the Nebraska Workers' Compensation Act unless the entity is a certified managed care plan under these rules.

C. No employee may be required to receive services under a managed care plan, including but not limited to a preferred provider organization, point of service plan, health maintenance organization, or similar entity, unless the plan has been certified by the court.

Sections 48-120, 48-120.02, 48-163, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 52

MANAGED CARE
APPLICATION FOR CERTIFICATION

Words in italics are defined in Rule 49.

A. Application. Any person or entity may make written application for certification by the court of a plan to provide management of quality treatment to injured employees for injuries and diseases *compensable* under the Nebraska Workers' Compensation Act. Any such application shall be submitted to the court, together with one identical copy, and shall include the following information.

1. The Application must describe the manner in which the plan will meet the requirements of Rule 51 to Rule 61 and section 48-120.02, including a description of the times, places, and manner of providing *health care services* under the plan, and a statement describing how the plan will ensure an adequate number of each category of *health care providers* listed in Rule 53,C is available to give employees convenient geographic accessibility to all categories of *health care providers* and adequate flexibility to choose the *primary treating physician* pursuant to Rule 53,E,3.
2. The Application must identify the following (an individual may act in more than one capacity):
    a. the names of all directors and officers of the *managed care plan*;
    b. the title and name of the person to be the day-to-day administrator of the *managed care plan*;
    c. the title and name of the person to be the administrator of the financial affairs of the *managed care plan*;
    d. the name and medical specialty, if any, of the medical director; and
    e. the name, address, and telephone number of a communication liaison for the court, insurer, risk management pool, employer, and the employee.
3. The Application must provide a copy of any standard contract used with *health care providers* who will deliver services under the *managed care plan*, and a description of any other relationships with *health care providers* who may deliver services to a covered employee, together with a copy of any related contract. The *managed care plan* must provide a list of names, clinics, addresses, telephone numbers, types of license, certification or registration, and specialties for the *health care providers* subject to the contracts. The *managed care plan* must also submit a statement that all licensing, certification or registration requirements for the *health care providers* are current and in good standing in Nebraska or the state in which the *health care provider* is practicing.
4. The Application must identify any entity, other than *health care providers*, with whom the *managed care plan* has a joint venture or other agreement to perform any of the functions of the *managed care plan*, together with a description of the specific functions to be performed by each such entity. Copies of the related contracts must also be provided.
5. The Application must disclose to the court the existence of any of the following factors and any equivalent interest the *managed care plan* has

in an insurer, risk management pool or employer. The court may consider these factors and any other relevant information in determining whether a *managed care plan* shall be certified. If an insurer, risk management pool, or employer, or any member of the staff of such entity:

a. directly participates in the formation or certification of the plan; or

b. occupies a position as a director, or other governing member, officer, agent, or employee of the plan; or

c. has any ownership interest or similar financial or investment interest in the *managed care plan*; or

d. enters into any contract with the plan that limits the ability of the plan to accept business from any other source; or

e. has any relationship not listed above with a *managed care plan*, other than a contract for the provision of medical, surgical, and hospital services under the Nebraska Workers' Compensation Act.

Rule 52,A,5 is not intended to prohibit an insurer, risk management pool, or employer, from forming, owning, or operating a *managed care plan*, so long as the plan includes adequate safeguards to insure fairness and equity in the operation of the plan and in the provision of medical, surgical, or hospital services under the plan.

6. The Application must include satisfactory evidence of ability to meet the financial requirements necessary to ensure delivery of service in accordance with the plan.

7. The Application must include a copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, as well as the bylaws or similar document, if any.

8. The Application must identify one place of business in this state where the plan is administered and membership records and other records are kept, or if the plan is located outside the state of Nebraska, the Application must identify one such place of business in such other state and must also include a statement that the plan agrees and stipulates to the jurisdiction of Nebraska courts for all purposes.

B. Fees. Each application for original certification or application for certification following revocation must be accompanied by a nonrefundable fee of $1,500. The fee for the annual report is established in Rule 57.

C. Notification; approval or denial.

1. An application received by the court shall be approved if such application meets all the requirements as set out in Rules 51 through 61. The court may request of the applicant further information or clarification of information submitted pursuant to Rule 52,A,1 through Rule 52,A,8. Failure to respond to a request from the court or failure to meet the requirements shall result in a denial of certification. A letter detailing the reason(s) for denial shall be sent to the applicant within five working days of the decision by the court to deny the application.
2. An applicant denied certification pursuant to Rule 52,C,1 shall be permitted to reapply no earlier than 30 days after receipt of the notice of denial of certification. Such reapplication shall be accompanied by a nonrefundable fee of $750. In no event shall an entity be allowed to reapply for one year after having been denied certification three consecutive times.

Sections 48-120, 48-120.02, 48-163, R.S. Supp., 2002.
Effective date October 27, 1998.

RULE 53

MANAGED CARE
REQUIREMENTS FOR CERTIFICATION

Words in italics are defined in Rule 49.

A. In order to become and remain certified under these rules, a *managed care plan* must meet all the requirements of Rule 51 through Rule 61 as well as those listed in section 48-120.02.

B. The *managed care plan* must ensure provision of quality *health care services* that meet all uniform treatment standards adopted by the plan or which may be prescribed by the court, and all *health care services* that may be required under the Nebraska Workers' Compensation Act in a manner that is timely, effective and convenient for the employee. The employer shall remain liable for any *health care service* required under the Act that the *managed care plan* does not provide.

C. The *managed care plan* must have contracted for, at a minimum, the following types of *health care services and providers*, unless the *managed care plan* is

unable to contract for a particular service or type of provider. If the *managed care plan* is unable to contract for a particular service or provider, then the *managed care plan* shall provide an explanation. The *managed care plan* must provide to an employee at a minimum, when necessary, the following types of *health care services and providers*:

1. medical doctors in at least one of the following specialized fields: family practice, internal medicine, occupational medicine, physiatry or emergency medicine;
2. orthopedic surgeons;
3. specialists in hand and upper extremity surgery;
4. neurologists;
5. neurosurgeons;
6. general surgeons;
7. chiropractors;
8. podiatrists;
9. osteopaths;
10. dentists;
11. dermatologists;
12. ophthalmologists;
13. optometrists;
14. physical therapists;
15. occupational therapists;
16. psychologists;
17. psychiatrists;
18. diagnostic pathology and laboratory services;
19. radiology services;
20. hospital services;
21. outpatient surgery; and
22. urgent care services.

D. The *managed care plan* must provide for referral for any services that are not specified above in Rule 53,C that are required under the Nebraska Workers' Compensation Act.

E. The *managed care plan* must include procedures to ensure that employees will receive *health care services* in accordance with the following:

1. Employees must receive initial evaluation by a *participating* licensed *physician* in one of the disciplines listed below in Rule 53,E,3 within 24 hours of the employee's request to the *managed care plan* for treatment following an injury. The *managed care plan* may select the *physician* to do the evaluation.
2. In cases where the employee has received treatment for the work injury by a *physician* outside the *managed care plan* under Rule 56,A,1 or Rule 56,A,6 the employee must receive initial evaluation or treatment by a *participating* licensed *physician* within five working days of the employee's request for a change of doctor, or referral to the *managed care plan*. The *managed care plan* may select the *physician* to do the evaluation.
3. Following the initial evaluation and upon request, the employee must be allowed to choose to receive ongoing treatment from any one *participating physician* in one of the disciplines listed below as the *primary treating physician*, if the *physician* is available within the mileage limitations established in Rule 53,E,7, if the treatment is required under the Nebraska Workers' Compensation Act, if the treatment is within the provider's scope of practice, and if the treatment is appropriate under the standards of treatment adopted by the *managed care plan*:
   a. medical doctors;
   b. chiropractors;
   c. podiatrists;
   d. osteopaths; or
   e. dentists.

   An evaluating *physician* may also be offered as a *primary treating physician*.

   The *primary treating physician* may arrange for any consultation, referral, or extraordinary or other *specialized medical services* as the nature of the injury shall require, as permitted under the *managed care plan*.
4. Employees must receive any required treatment, diagnostic tests, or *specialized medical services* in a manner that is timely, effective, and convenient for the employee.
5. Employees must be allowed to change *primary treating physicians* within the *managed care plan* at least once by making application for such change

to the plan without proceeding through the *managed care plan*'s dispute resolution process. A change of *physician* from the evaluating *physician* to a *primary treating physician* for ongoing treatment is not considered a change of *physician*, unless the employee has received treatment from the evaluating *physician* more than once for the injury.

6. Employees must be able to receive information at no cost on a 24-hour basis regarding the availability of *health care services* under the *managed care plan*. The information may be provided through recorded telephone messages after normal working hours. The message must include information on how the employee can obtain emergency services or other urgently needed care, and how the employee can receive an evaluation.
7. Employees must have access to the evaluating and *primary treating physician* within 30 miles of either the employee's place of employment or residence if either the residence or place of employment is within a city with a population of 5,000 or more. If both the employee's residence and place of employment are outside a city with a population of 5,000 or more, the allowable distance is 60 miles. If the *primary treating physician* is not available within the stated mileage restrictions then a *nonparticipating physician* may be selected pursuant to Rule 56,A,5.

F. The *managed care plan* must designate the procedures for approval of services from a *physician* outside the *managed care plan* as permitted in Rule 56,A,1 through Rule 56,A,6, and how such *physician* will be informed of the rules, terms, and conditions of the *managed care plan*, and the procedures for referring an employee to the *managed care plan* for any other treatment that the employee may require.

G. The *managed care plan* must include a procedure for peer review and utilization review as specified in Rule 59.

H. The *managed care plan* must include a procedure for internal dispute resolution as specified in Rule 58.

I. The *managed care plan* must describe how employers, insurers, and risk management pools will be provided with information that will inform employees of all choices of *physician* under the plan and how employees can gain access to those *physicians*. The plan must submit a proposed notice to employees, which may be customized according to the needs of the employer, but which must include the information required by Rule 55.

J. The *managed care plan* must describe how aggressive medical case management will be provided as specified in Rule 60, and how a program for early

return to work and cooperative efforts to promote workplace health and safety consultative services will be provided.

K. The *managed care plan* must describe a procedure or program through which *health care providers* may obtain information on the following topics:

1. treatment parameters adopted by the plan;
2. maximum medical improvement;
3. permanent partial impairment rating;
4. return to work and disability management;
5. *health care provider* obligations in the workers' compensation system; and
6. other topics the *managed care plan* deems necessary to obtain cost effective, quality medical treatment and appropriate return to work for an injured employee.

The medical director or designee must be available as a consultant on the topics listed above in Rule 53,K,1 through Rule 53,K,6 to any *health care provider* delivering services under the *managed care plan*.

L. The *managed care plan* must describe the treatment standards it has adopted or developed, if any, for *health care services* that are to be used in the treatment of workers' compensation injuries. All participating *health care providers* and those nonparticipating providers subject to the rules, terms and conditions of the *managed care plan* shall be governed by such treatment standards. This paragraph does not, however, require ongoing treatment in individual cases if the treatment is not medically necessary, even though the maximum amount of treatment permitted under any standard has not been given.

M. The *managed care plan* must provide that payment for medical, surgical, and hospital services under the plan shall not exceed the maximum fees established by the court in the Schedule of Medical and Hospital Fees, unless the court has excluded the *managed care plan* from the application of such schedule. The *managed care plan* may, however, provide for payment to participating providers which are lower than those established pursuant to such schedule.

N. The *managed care plan* must maintain a standardized claimant medical recordkeeping system designed to facilitate entry of information into computerized databases.

O. The *managed care plan* must provide a timely and accurate method of reporting to the court necessary and useable information regarding medical, surgical, and hospital service cost and utilization to enable the court to determine the effectiveness of the plan.

P. The *managed care plan* must maintain and provide to the court on request any other information or data as the court considers necessary.

Sections 48-120, 48-120.02, 48-163, R.S. Supp., 2002.
Effective date October 27, 1998.

RULE 54

MANAGED CARE
COVERAGE

A. Contracts.

1. In order to provide management of treatment for injuries and diseases compensable under the Nebraska Workers' Compensation Act a managed care plan must contract with:
   a. an insurer licensed by the Nebraska Department of Insurance to write workers' compensation insurance in this state that has issued a current workers' compensation insurance policy or policies; or
   b. a risk management pool formed pursuant to the Intergovernmental Risk Management Act that provides group self insurance to member employers; or
   c. an individual employer approved for self insurance by the court.
2. All contracts pursuant to Rule 54,A,1 shall specify the billing and payment procedures that will be utilized, and how the aggressive case management, early return to work, and cooperative efforts to promote workplace health and safety consultative services will be provided.
3. All contracts pursuant to Rule 54,A,1 shall specify that any contractual obligations of an insurer, risk management pool, or self insured employer to allow a managed care plan to provide medical, surgical, or hospital services for employees pursuant to the Nebraska Workers' Compensation Act shall be null and void upon revocation of the certification of the managed care plan.

4. Once compensability has been accepted or determined, the employer may require that employees subject to the contract shall receive medical, surgical, and hospital services in the manner prescribed in the contract.
5. The employer shall remain liable for any health care services required under the Nebraska Workers' Compensation Act that the managed care plan does not provide.

B. Multiple Plans. An insurer, risk management pool, or self insured employer may contract with multiple managed care plans to provide coverage for employers. When an insurer, risk management pool, or self insured employer contracts with multiple managed care plans to provide coverage for the same employer, and more than one such plan has participating physicians within the mileage restrictions established pursuant to Rule 53,E,7 whose scope of practice is appropriate for treatment of the injury in question, the employee shall have the right to select the managed care plan that will manage the employee's care; except that if any such certified managed care plan also provides group health insurance for the employer and the employee is obligated to receive services under the group health insurance plan, then that plan, if the employer so elects, shall also manage the employee's care for workers' compensation purposes.

C. Coverage.

1. If an employee gives notice of injury to an employer under the Nebraska Workers' Compensation Act on or after the effective date of the managed care plan contract with the insurer, risk management pool, or self insured employer, and if compensability has been accepted or determined, then the employee may be required to receive services under the managed care plan; except that an employee may not be required to receive services under the managed care plan until the notice required by Rule 55 has been given to the employee.
2. If the employer received notice of the injury before the effective date of the managed care plan contract, the employee may not be required to receive services under the managed care plan until the employee requests a change of physician. At that time the employee may be required to receive further services under the managed care plan.
3. Prior to acceptance or determination of compensability, or subsequent to the denial of compensability, the employee may not be required to receive services under a managed care plan.

4. If compensability is denied by the insurer, risk management pool, or self insured employer, the employee may leave the managed care plan and the employer shall be liable for medical, surgical, and hospital services previously provided.

D. Termination of Coverage.

1. To ensure continuity of care, the managed care plan contract shall specify the manner in which an employee will receive health care services when a managed care plan contract or a contract with a health care provider terminates.
2. When a contract with a participating primary treating physician terminates, the employee may continue to treat with such physician if the physician remains in good standing in Nebraska or the state in which he or she practices, and if the physician agrees to refer the employee to the managed care plan for any other treatment that the employee may require with respect to the injury in question, and if the physician agrees to comply with all of the rules, terms, and conditions of the managed care plan with respect to treatment of the injury in question.
3. When managed care plan coverage for an employee is transferred from one managed care plan to another, the employee may continue to treat with the primary treating physician selected under the old plan if such physician agrees to refer the employee to the new managed care plan for any other treatment that the employee may require with respect to the injury in question, and if the physician agrees to comply with all of the rules, terms, and conditions of the new managed care plan with respect to treatment of the injury in question. If the employee requests a change in the primary treating physician, further services will be provided under the new managed care plan.

Sections 48-120, 48-120.02, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 55

MANAGED CARE
NOTICE TO EMPLOYEE

Words in italics are defined in Rule 49.

An employee is not required to receive services under a *managed care plan* until the insurer, risk management pool, or self insured employer gives the employee notice of the information listed below in this rule. Individual notice of such information must be given at the time the employee becomes subject to the contract (see Rule 53,I). The notice must include the following information:

A. The employer is covered by the named *managed care plan* to provide all required treatment for work related injuries after a specified date. An employee sustaining an injury prior to the specified date is required to receive services under the plan only if the employee changes *physicians*.

B. The toll free telephone number of the *managed care plan* where the employee can receive answers to questions about managed care.

C. The employee may receive treatment from a medical doctor, chiropractor, podiatrist, osteopath, or dentist under the plan, if the treatment is available within the community and the scope of practice of the *physician* is appropriate for the treatment of the injury in question.

D. How the employee can access care under the *managed care plan*, how the employee can identify eligible *physicians*, and the toll free 24 hour telephone number of the *managed care plan* that informs employees of available services.

E. The employee may be required to receive services from a *participating physician* under the *managed care plan* except in the following circumstances:

1. if the employee or an *immediate family member* has treated with a *physician* prior to the date of injury who can provide treatment appropriate for the injury in question, if the employee selects such *physician* according to rules established by the court, if such *physician* agrees to refer the employee to the *managed care plan* for any other treatment that the employee may require, and if such *physician* agrees to comply with all of the rules, terms, and conditions of the *managed care plan*; or
2. if the employer fails to notify the employee of the right to select a *family physician* according to the rules established by the court;

3. for *emergency medical treatment*; or

4. in cases of injury requiring dismemberment or injuries involving *major surgical operation*, if the employee selects the *physician* to perform the operation and such *physician* agrees to refer the employee to the *managed care plan* for any other treatment that the employee may require, and if such *physician* agrees to comply with all of the rules, terms, and conditions of the *managed care plan*; or

5. after *compensability* has been denied by the insurer, risk management pool, or self insured employer; or

6. if there is no *participating primary treating physician* available within the mileage restrictions established in Rule 53,E,7 of the Rules of Procedure of the Nebraska Workers' Compensation Court.

Sections 48-120, 48-120.02, 48-163, R.S. Supp., 2002.
Effective date October 27, 1998.

RULE 56

MANAGED CARE PHYSICIANS WHO ARE NOT PARTICIPATING PHYSICIANS

Words in italics are defined in Rule 49.

A. Authorized Services. For provisions relating to choice of *physician* generally, see Rule 50. A *physician* who is not a *participating physician* under the *managed care plan* may provide services to an employee in any of the circumstances listed below under this rule if the scope of practice of the *nonparticipating physician* is appropriate for treatment of the injury in question.

1. A *nonparticipating physician* may be selected as the *primary treating physician* by the employee if:

   a. the *physician* is a *family physician*;

   b. the *physician* agrees to refer the employee to the *managed care plan* for any other treatment that the employee may require;

   c. the *physician* agrees to comply with all of the rules, terms, and conditions of the *managed care plan*; and

d. the employee selects the *physician* as required in Rule 50,A following notice by the employer as required in Rule 50,B.

If the *physician* selected by the employee does not agree to refer the employee to the *managed care plan* for any other treatment that the employee may require or to comply with all of the rules, terms, and conditions of the *managed care plan*, the *physician* may not provide services to the employee and the employee may select another *nonparticipating physician* pursuant to Rule 56 A, 1.

2. A *nonparticipating physician* may be selected as the *primary treating physician* by the employee if the employer does not give the employee notice, as described in Rule 50, B,2, of the right to choose a *family physician* as the *primary treating physician*.

3. A *nonparticipating physician* may provide services to an employee for *emergency medical treatment*.

4. A *nonparticipating physician* may deliver services to an employee when the employee is referred to such *physician* by the *managed care plan*.

5. A *nonparticipating primary treating physician* may be selected by the employee to provide services if there is no *participating physician* available within the mileage restrictions established in Rule 53,E,7, or if there is an insufficient number of *participating physicians* within the mileage restrictions to permit the employee to change *primary treating physicians* as permitted under the plan (see Rule 53,E,5); except that a *nonparticipating physician* may be selected in such circumstances only if no *participating physician* is available closer to either the residence or place of employment of the employee whose scope of practice is appropriate for treatment of the injury in question.

6. A *nonparticipating physician* may be selected by the employee in cases of injury requiring dismemberment or injuries involving *major surgical operation* to perform the operation if:

   a. the *physician* agrees to refer the employee to the *managed care plan* for any other treatment that the employee may require; and

   b. the *physician* agrees to comply with all of the rules, terms, and conditions of the *managed care plan*.

7. If *compensability* is denied by the insurer, risk management pool, or self insured employer, the employee may leave the *managed care plan* and the employer shall be liable for medical, surgical, and hospital services previ-

ously provided. Under such circumstances a *nonparticipating physician* may be selected by the employee to provide services.

B. Change of *Physician*. If the employee requests a change of *nonparticipating primary treating physician*, further services shall be provided in accordance with Rules 53,E.

C. Disputes. Any dispute relating to the selection of a *nonparticipating physician* pursuant to Rule 56,A,1 through 56,A,6, as well as any dispute relating to the obligation of any *nonparticipating physician* to make referrals into the *managed care plan* or to comply with the other rules, terms, and conditions of the *managed care plan* shall be resolved according to the dispute resolution procedures of the *managed care plan*. Any *nonparticipating physician* who has an obligation to make referrals into the *managed care plan* or to comply with the other rules, terms, and conditions of the *managed care plan* and who fails to refer or comply, is subject to denial of payment for the related services.

Sections 48-120, 48-120.02, R.S. Supp., 2002.
Effective date October 27, 1998.

RULE 57

MANAGED CARE
REPORTING REQUIREMENTS

A. Contracts. A managed care plan shall provide the court with copies of the following contracts:

1. Contracts between the managed care plan and any insurer, risk management pool, or self-insured employer, signed by the parties, within 30 days of execution of such contracts. Such contracts must include a listing of all employers covered by each contract, including the employer's name, address, telephone number, unemployment insurance identification number, and estimated number of employees and location of the employees covered by the managed care plan contract.
2. Contracts between the managed care plan and any entity other than health care providers that perform any of the functions of the managed care plan, which have not previously been provided with the application for certification. These must be signed by the parties and submitted within 30 days of execution of such contracts.

3. New standard contracts between the managed care plan and health care providers who will deliver services under the plan, if such contracts have not previously been provided with the application for certification. These must be submitted within 30 days of adoption. Such new contracts must meet the requirements set out in Rule 52,A,3.

B. Amendments; Changes. Within 30 days of execution or adoption, a managed care plan shall provide to the court the following amendments or changes.

1. Amendments to any of the contracts listed in Rule 57,A as well as amendments to any contracts previously provided with the application for certification.
2. Changes in the managed care plan's ownership or organizational status, or the affiliation of the managed care plan with an insurer, risk management pool, or employer other than through a contract to provide management of treatment for injuries and diseases compensable under the Nebraska Workers' Compensation Act.
3. Any other amendments to the certified managed care plan.

C. Annual reporting. In order to maintain certification, each managed care plan shall, with a nonrefundable fee of $400, provide to the court within 30 days following each anniversary of certification the following information:

1. A current listing of participating health care providers, including names, clinics, addresses, telephone numbers, types of license, certification or registration, and specialties. The managed care plan must also submit a statement that all licensing, certification or registration requirements for the providers are current and in good standing in Nebraska or the state in which the provider is practicing.
2. A summary of any sanctions or punitive actions taken by the managed care plan against any of its participating providers.
3. A summary of any peer review, utilization review, reported complaints and dispute resolution proceedings showing cases reviewed, issues involved, and action taken.
4. Any other information requested by the court.

D. Data, Requested or Required. The managed care plan must report to the insurer, risk management pool, or self insured employer any data regarding medical, surgical, and hospital services related to a workers' compensation claim requested by the insurer, risk management pool, or self insured em-

ployer to determine compensability under the Nebraska Workers' Compensation Act and any other data required by statute or rule.

E. Monitoring. The court may monitor and conduct periodic audits and special examinations of the managed care plan as necessary to ensure compliance with the managed care plan certification and performance requirements. All records of the managed care plan and its participating health care providers relevant to determining compliance with Rule 51 through Rule 61, and sections 48-120 and 48-120.02, shall be disclosed within a reasonable time after request by the court. Records must be legible and cannot be kept in a coded or semicoded manner unless a legend is provided for the codes.

Sections 48-120, 48-120.02, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 58

MANAGED CARE
DISPUTE RESOLUTION

A. Disputes that arise between the employee, health care provider, managed care plan, insurer, risk management pool, or employer, involving the question of inappropriate, excessive, or not medically necessary treatment, medical disputes, and those disputes listed under Rule 56,C shall first be processed without charge to the employee or health care provider through the dispute resolution procedure of the managed care plan. The managed care plan dispute resolution procedure must be completed within 30 days of receipt of a written request.

B. Under section 48-120.02, an employee shall exhaust the dispute resolution procedure of the certified managed care plan prior to filing a petition or otherwise seeking relief from the court on an issue related to managed care. If an employee has exhausted the dispute resolution procedure of the managed care plan, the employee may submit the dispute to the court for informal dispute resolution or may seek a medical finding by an independent medical examiner. No petition may be filed with the court pursuant to section 48-173 solely on the issue of the reasonableness and necessity of medical treatment unless a medical finding on such issue has been rendered by an independent medical examiner, but such finding shall not thereafter preclude the filing of a petition. A petition may be filed with the court for the purpose of avoiding the running

of the applicable statute of limitations in which case the petition shall be deemed filed with the court for purposes of the statute of limitations and will be held in abeyance until the medical finding on the issue has been received from the independent medical examiner.

Section 48-173, R.R.S. 1998, and sections 48-120, 48-120.02, 48-134.01, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 59

MANAGED CARE
PEER REVIEW AND UTILIZATION REVIEW

A. Peer review. The managed care plan shall implement a system for peer review to prevent inappropriate, excessive, or not medically necessary treatment and to improve the quality of patient care and cost effectiveness of treatment. Peer review must include at least one health care provider of the same discipline being reviewed. The peer review must be designed to evaluate the quality of care given by a health care provider to a patient or patients. The plan must describe in its application for certification how the providers will be selected for review, the nature of the review, and how the results will be used.

B. Utilization review. The managed care plan shall implement a program for utilization review to prevent inappropriate, excessive, or not medically necessary treatment and to improve the quality of patient care and cost effectiveness of treatment. The program must include the collection, review, and analysis of group data to improve overall quality of care and efficient use of resources. In its application for certification, the managed care plan must specify the data that will be collected, how the data will be analyzed, and how the results will be applied to improve patient care and increase cost effectiveness of treatment.

Sections 48-120, 48-120.02, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 60

MANAGED CARE
MEDICAL CASE MANAGEMENT

A. Role of case manager. A medical case manager in a managed care plan shall monitor, evaluate, and coordinate the delivery of quality, cost effective medical treatment and other health care services needed by an injured employee to assist him or her in reaching maximum medical improvement, and shall promote an appropriate, prompt return to work. Medical case managers shall facilitate communication between the employee, employer, insurer, risk management pool, health care provider, managed care plan, and any assigned vocational rehabilitation counselor to achieve these goals. The managed care plan must describe in its application for certification how injured employees will be selected for medical case management, the services to be provided, and who will provide the services.

B. Qualifications of medical case manager. A medical case manager, for purposes of a managed care plan, shall have attained the educational and/or employment experience set forth below in this rule. Acceptable case management experience must be full-time paid employment. Acceptable clinical experience involves full-time, paid employment either in a professional clinical setting (e.g., hospital/clinic, home health care, physician's private practice, etc.) or with a private rehabilitation firm. Additionally, professionally supervised internships, preceptorships, practica—whether paid or unpaid—may be counted toward meeting the full-time employment and clinical experiences. Volunteer work experience activities, however, may not be counted toward meeting the full-time employment or clinical experience requirements.

1. Designation of Certified Case Manager (CCM) by the Certification of Insurance Rehabilitation Specialists Commission for Case Manager Certification, or;
2. Designation of Certified Insurance Rehabilitation Specialist (CIRS) by the Certification of Insurance Rehabilitation Specialists Commission, or;
3. Current licensure as a Registered Nurse (RN), or;
4. Current licensure as a Licensed Practical Nurse (LPN) and 18 months supervised clinical experience and six months acceptable case management experience, or;

5. A baccalaureate degree (in a field other than nursing), current professional licensure or national certification in a health and human services profession, and at least 24 months employment experience, of which six months must be acceptable case management experience and 18 months must be supervised clinical experience.
6. Extensive experience in medical case management may be substituted for any of the foregoing.

Sections 48-120, 48-120.02, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 61

MANAGED CARE
SUSPENSION; REVOCATION

A. Criteria. The certification of a managed care plan may be suspended or revoked by the court if:

1. the plan for providing services or a contract with the insurer, risk management pool, self insured employer, or health care provider fails to meet the requirements of Rule 51 through Rule 61 or sections 48-120 and 48-120.02 or;
2. service under the plan is not being provided according to the terms of the plan; or
3. any false or misleading information is submitted by the managed care plan or participating provider; or
4. the managed care plan continues to use the services of a health care provider whose license, registration, or certification has been suspended or revoked.

B. Complaints; investigation. Complaints pertaining to violations of Rule 51 through 61 or sections 48-120 and 48-120.02 by the managed care plan shall be directed in writing to the court. On receipt of a written complaint, or after monitoring the managed care plan operations, the court may investigate the alleged violation. The investigation may include, but shall not be limited to, request for and review of pertinent managed care plan records. If the investigation reveals reasonable cause to believe that there has been a violation, the certification may be suspended or revoked.

C. Immediate Revocation. Notwithstanding Rules 61,A and 61,B above, in any case where the court finds a serious danger to the public health or safety the court may immediately revoke the certification of the managed care plan.

D. Effects.

1. An employee is no longer required to receive services under a managed care plan if the managed care plan's certification is revoked.
2. Any contractual obligations of an insurer, risk management pool, or self insured employer to allow a managed care plan to provide medical, surgical, or hospital services for employees pursuant to the Nebraska Workers' Compensation Act shall be null and void upon revocation of the certification of the managed care plan.
3. Any contractual obligations of a health care provider or other entity to deliver medical, surgical, or hospital services pursuant to the Nebraska Workers' Compensation Act, or to comply with any rules, terms, and conditions of the managed care plan or to make referrals into the managed care plan shall be null and void upon revocation of the certification of the managed care plan.

Sections 48-120, 48-120.02, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 62

INDEPENDENT MEDICAL EXAMINERS
APPOINTMENT

Words in italics are defined in Rule 49.

A. Qualifications. To be eligible for appointment by the court to the list of qualified *independent medical examiners* the *physician* must:

1. be licensed and in good standing in Nebraska or the state in which he or she practices;
2. be highly experienced and competent in his or her specific field of expertise and in the treatment of work-related injuries; and
3. be knowledgeable of workers' compensation principles and the workers' compensation system in Nebraska, as demonstrated by prior experience and/or education.

B. Appointment. Appointment of *physician*s to the list of qualified *independent medical examiners*, and maintenance and periodic validation of such list shall be by a majority vote of the judges of the court.

C. Application for Appointment. To request appointment to the list of qualified *independent medical examiners* a *physician* shall complete and forward to court an application form provided by the court, and shall also verify that the *physician*, if appointed, will:

1. provide independent, impartial and objective medical findings in all cases that come before him or her;
2. decline a request to serve as an *independent medical examiner* only for good cause shown;
3. conduct an examination, if necessary, in order to render findings on the questions and issues submitted, within the time frame established in Rule 64,C;
4. submit a written report to the parties and the court within the time frame established in Rule 64,E;
5. accept as payment in full for services rendered as an *independent medical examiner* the fees established pursuant to Rule 65;
6. submit to a review pursuant to Rule 62,E; and
7. comply with all of the other provisions of Rule 62 through Rule 67 and section 48-134.01.

D. Disclosure. As part of the application the *physician* shall identify any employer, insurer, attorney, employee group, *managed care plan*, or representatives of any of the above to whom the *physician* is under contract or who regularly uses the services of the *physician*.

E. Review. The court may at its discretion review the performance of any *physician* appointed to the list of qualified *independent medical examiners*. Such review may include, but not be limited to, the timeliness of submission of medical findings, the quality of the reports submitted, and any other aspects of the performance of the examiner as determined by the court.

Section 48-173, R.R.S. 1998, and sections 48-120, 48-120.02, 48-134.01, 48-163, R.S. Supp., 2002.
Effective date December 1, 1999.

RULE 63

INDEPENDENT MEDICAL EXAMINERS
SELECTION

Words in italics are defined in Rule 49.

A. Once a dispute regarding medical, surgical, or hospital services furnished or to be furnished under the Nebraska Workers' Compensation Act has arisen any party or the court on its own motion may submit the dispute for a medical finding by an *independent medical examiner*.

B. If the parties to a dispute cannot agree on an *independent medical examiner* of their own choosing, the court shall assign one from the list of qualified *independent medical examiners* maintained by the court. Assignments by the court from the list shall be made by means of a revolving selection process established by the court, and may take into account the specialty and location of the examiner. The requesting party may express a preference with regard to the specialty of the *physician* when submitting a request for assignment, but the court shall not be bound by such preference when making an assignment.

C. In order to be eligible for assignment, a qualified *independent medical examiner*:

1. shall not be the employee's treating *physician* with respect to the injury for which the claim is being made, and shall not have treated the employee with respect to such injury; and
2. shall not have previously examined the employee at the request of any party with respect to the injury for which the claim is being made.

D. To request assignment of a qualified *independent medical examiner* the requesting party shall complete and forward to the court an application form provided by the court setting out any questions or issues that they wish to submit to the *independent medical examiner*. At the same time, the requesting party shall serve a copy of the application on all other parties. Within ten calendar days of being served the other parties shall submit to the court in writing any questions or issues that they wish to submit to the *independent medical examiner*. The court shall assign a qualified *independent medical examiner* within seven calendar days

thereafter, and shall issue a notification by regular mail to the examiner and the parties to include:

1. the name, address and telephone number of the assigned examiner;
2. an identification of the disputed issues upon which the *independent medical examiner* shall render a finding;
3. the obligation of the insurer, risk management pool, or self insured employer to provide copies of records and information pursuant to Rule 63,E;
4. the obligation of any party, other than the insurer, risk management pool, or self insured employer, to provide copies of records and information pursuant to Rule 63,F; and
5. any other information as determined by the court.

E. Following notice of assignment by the court, or notice of agreement by the parties pursuant to Rule 67,A, the insurer, risk management pool, or self insured employer shall send to the examiner copies of all records and information in its possession that are relevant to the disputed issues, and shall send to all other parties and to the court a description of all such records and information. Such copies, information and description shall be sent by regular mail within seven calendar days of receipt of the notification of assignment or agreement, at no cost to the examiner, the court or any other party.

F. Following receipt of the description of records and information from the insurer, risk management pool, or self insured employer, any other party shall send to the examiner copies of any relevant records and information in its possession that were not previously provided by the insurer, risk management pool, or self insured employer, and shall send to all other parties and to the court a description of all such records and information. Such copies, information and description shall be sent by regular mail within seven calendar days of receipt of the description from the insurer, risk management pool, or self insured employer, at no cost to the examiner, the court or any other party.

G. If no records or information are in the possession of the insurer, risk management pool, or self insured employer as provided in Rule 63,E or any other party as provided in Rule 63,F, then a letter to this effect shall be sent

to the examiner with copies to all other parties and the court, together with information as to the location of any records or information of which they are aware but which are not in their possession. Necessary records not in the possession of any party, including any records requested by the examiner, shall be obtained by the party most able to do so, with the cost to be paid by the insurer, risk management pool, or self insured employer.

H. All records and information provided pursuant to Rule 63,E and 63,F shall be in chronological order by provider, and shall be accompanied by an index to the submitted records and information.

I. An *independent medical examiner* assigned by the court or agreed to by the parties pursuant to Rule 67 to render a medical finding shall not refer the employee for treatment, nor shall the examiner treat the employee with respect to the injury for which the claim is being made unless the examiner:

1. has completed his or her duties as the *independent medical examiner*;
2. agrees to treat the employee; and
3. either becomes the *primary treating physician* as agreed to by the employee and employer, or is selected by the employee to do surgery when the injury involves dismemberment or a *major surgical operation*.

J. An *independent medical examiner* may decline assignment by the court only for good cause shown.

K. If an *independent medical examiner* has submitted a written report pursuant to Rule 64,E stating findings on the questions or issues raised, no party may request court assignment of another *independent medical examiner* on the same questions or issues.

L. Disputes relating to treatment provided or to be provided through a *managed care plan* shall be processed through the internal dispute resolution procedures of the *managed care plan* prior to the filing with the court of a request for assignment of an *independent medical examiner*.

Section 48-173, R.R.S. 1998, and sections 48-120, 48-120.02, 48-134.01, R.S. Supp., 2002.
Effective date December 17, 2002.

RULE 64

INDEPENDENT MEDICAL EXAMINERS PROCEDURES BEFORE THE INDEPENDENT MEDICAL EXAMINER

Words in italics are defined in Rule 49.

A. An *independent medical examiner* shall render medical findings in any dispute submitted to the examiner on the medical condition of the employee and related issues, including, but not limited to:

1. whether the employee is able to perform any gainful employment temporarily or permanently;
2. what physical restrictions, if any, would be imposed on the employee's employment;
3. whether the employee has reached maximum medical improvement;
4. the existence and extent of any permanent physical impairment;
5. the reasonableness and necessity of any medical treatment previously provided or to be provided to the employee; and
6. any other medical question(s) as may pertain to the causality and relatedness of the medical condition to the employment.

B. In addition to the review of records and information, the *independent medical examiner* may examine the employee as often as the examiner determines necessary in order to render medical findings on the questions and issues submitted. The examiner may also perform any necessary tests and may also arrange for any necessary tests, evaluations and examinations to be performed by other *health care providers*, but shall not refer the employee to any facility in which the examiner has an ownership or similar financial or investment interest, unless the type of facility or services are not otherwise available within 60 miles of the residence or place of employment of the employee.

C. If it is determined by the *independent medical examiner* that it is necessary to examine the employee in order to render medical findings on the disputed issues, then the examiner shall contact the employee to schedule the appointment. Such contact may be by telephone or in writing. Any such examination shall be conducted within 28 calendar days from notification of assignment by the court or notice of agreement by the parties pursuant to

Rule 67. The examiner shall immediately notify all parties and the court, in writing by regular mail, of the date, time, location, and purpose of the examination. If the employee fails to appear for a scheduled examination, or if an examination is cancelled within 48 hours of the scheduled time by the employee, then the examination shall not be rescheduled unless approved by the employer or insurance carrier or by order of the court.

D. All contact between the examiner and the parties, other than for the scheduling of an appointment for an examination and the examination, shall be in writing with copies to all other parties and the court.

E. After review of the records and information, and completion of any necessary examinations and/or additional tests, evaluations or examinations, the *independent medical examiner* shall submit a written report to the court and to all parties, stating the examiner's medical findings on the questions or issues raised and providing a description of the findings sufficient to explain the basis of those findings. Where only a review of records and information is required, such report shall be submitted within seven calendar days of receipt of all necessary records and information. If an examination and/or additional tests, evaluations or examinations are required, such report shall be submitted within seven calendar days of the completion of the examinations, additional tests or evaluations. The court may approve extension of time upon good cause shown by the examiner.

F. Requests for clarification of the *independent medical examiner's* findings must be submitted to the court, not to the *independent medical examiner*. Clarification will be permitted only with approval of a medical services specialist of the court. No request for clarification will be permitted if it is determined by the specialist to be overly burdensome to the examiner. Any party may depose the examiner in accordance with the Nebraska Discovery Rules for all Civil Cases.

G. The written report of the *independent medical examiner's* findings shall be admissible in a proceeding before the court, and may be received into evidence by the court on its own motion.

H. Once the *independent medical examiner* has submitted a written report stating findings on the questions or issues raised, no party may request court assignment of another *independent medical examiner* on the same questions or issues.

I. No petition may be filed with the court solely on the issue of reasonableness and necessity of medical treatment unless a medical finding on such issue has been rendered by an *independent medical examiner*, but such finding shall not thereafter preclude the filing of a petition. A petition may be filed with the court for the purpose of avoiding the running of the applicable statute of limitations in which case the petition shall be deemed filed with the court for purposes of the statute of limitations but will be held in abeyance until the medical finding on the issue has been received from the *independent medical examiner*.

J. Any *physician* acting without malice and within the scope of the provider's duties as an *independent medical examiner* shall be immune from civil liability for making any report or other information available to the court or for assisting in the origination, investigation, or preparation of the report or other information so provided.

Section 48-173, R.R.S. 1998, and sections 48-120, 48-134.01, R.S. Supp., 2002.
Effective date December 17, 2002.

RULE 65

INDEPENDENT MEDICAL EXAMINERS FEES AND COSTS

A. All fees with respect to services performed by an independent medical examiner shall be paid by the employer according to the following schedule.

1. The independent medical examiner shall bill his or her usual fees for services rendered as a medical examiner. Payment shall be the examiner's usual fee or the amount allowed under Rule 65,A,2, whichever is lower. The number of hours required shall be included with the bill, as well as a statement that the services were rendered as a court assigned or agreed to independent medical examiner.
2. The independent medical examiner shall receive up to $200 per hour up to a maximum of four hours for review of records and information, the performance of any necessary examinations, and the preparation of the written report. In a complex case an additional fee of up to $200 per hour for up to two additional hours may be allowed.

3. If additional diagnostic tests are required, payment for such tests whether performed by the independent medical examiner or by another health care provider at the request of the examiner, shall be in accordance with the court's Schedule of Medical and Hospital Fees. If additional evaluations or examinations are required and performed by another health care provider at the request of the examiner, payment shall be in accordance with the court's Schedule of Medical and Hospital Fees.

4. An independent medical examiner may require prepayment from the employer of up to $200 prior to submitting a report on the issues submitted. Any additional amounts owed to the examiner are payable upon submission of the examiner's written report.

5. If an employee fails to appear for a scheduled examination, or if an examination is cancelled by the employee or the employer within 48 hours of the scheduled time, the independent medical examiner may charge and receive up to $200, to be paid initially by the employer, subject to the right of the employer to be reimbursed by the employee if the failure to appear or the cancellation by the employee was without good cause.

B. Any dispute regarding payment for services rendered by an independent medical examiner that cannot otherwise be resolved by the examiner and the parties themselves shall be submitted for informal dispute resolution.

C. The employer shall pay all necessary and reasonable expenses of the employee incident to such examination, such as transportation, lodging, meals, and loss of wages, and when required, shall advance necessary costs. If the employee fails to appear for the scheduled examination, such expenses shall not be paid again if the examination is rescheduled.

Section 48-168, R.R.S. 1998, and sections 48-120, 48-134.01, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 66

INDEPENDENT MEDICAL EXAMINERS
REMOVAL

A. Removal of physicians from the list of qualified independent medical examiners shall be by request of the physician or by a majority vote of the judges of the court.

B. Grounds for removal include, but are not limited to:

1. a material misrepresentation on the application for appointment to the list; or
2. refusal or substantial failure to comply with the provisions of Rule 62 through Rule 66 or section 48-134.01.

C. In arriving at a determination as to whether to remove a physician from the list, the court may consider the character of the alleged violation and all of the attendant circumstances, and may confer with public or private medical consultants.

Sections 48-120, 48-134.01, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 67

INDEPENDENT MEDICAL EXAMINERS SELECTED BY AGREEMENT OF THE PARTIES

Words in italics are defined in Rule 49.

A. Nothing in Rule 62 through Rule 66 shall prohibit the parties from agreeing to the use of an *independent medical examiner* who is not on the list of qualified *independent medical examiners* established by the Court. If the parties agree to the use of an *independent medical examiner*, whether from the list of qualified *independent medical examiners* established by the Court or otherwise, Rules 63 through 65 shall apply. Written notice of any such agreement shall be provided by the parties to the examiner and to the Court on a form developed by the Court. If the agreed upon examiner is not on the list of qualified *independent medical examiners* established by the Court, the parties shall also obtain written agreement from the examiner that he or she will comply with Rules 63 through 65, and shall provide a copy of such agreement to the Court.

B. Any agreement between the parties to the use of an *independent medical examiner* shall specify the questions and issues to be submitted to the examiner for a finding.

C. If the parties agree to the use of a particular named *independent medical examiner* and the *independent medical examiner* has submitted a written report stating findings on the questions or issues raised, no party may re-

quest court assignment of an *independent medical examiner* on the same questions or issues.

Section 48-164, R.R.S. 1998, and sections 48-120, 48-134.01, 48-163, R.S. Supp., 2002.
Effective date July 1, 1997.

RULE 68

PROMULGATION OF RULES

A. The adoption, amendment or repeal of the rules and regulations necessary to carry out the intent and purpose of the Nebraska Workers' Compensation Act shall be controlled by the procedures set out in this rule.

B. For purposes of this rule, quorum shall mean a majority of the judges of the Nebraska Workers' Compensation Court.

C. Adoption and promulgation of rules and regulations:

1. No rule or regulation shall be adopted, amended, or repealed except after public hearing on the question of adopting, amending, or repealing such rule or regulation. All such hearings shall be open to the public. A quorum of the judges of the court shall be present and conduct such hearings. The proceedings shall be recorded and made available within ten working days.
2. Notice of all such public hearings shall be given at least 30 days prior to the date of the hearing.
    a. Notice shall be by publication in a newspaper having general circulation in the state.
    b. Notice shall be by regular mail to those subscribers whose names are on a list maintained by the court for that purpose alone.
    c. Notice shall be by regular mail to a list of the news media requesting notice of such hearings.
3. Draft copies or working copies of all rules and regulations proposed to be adopted, amended, or repealed shall be available to the public in the office of the court at the time of giving notice.
4. The adoption, amendment or repeal of any rule or regulation shall be accomplished only upon the affirmative vote of a majority of the judges of the court and, with respect to rules or regulations relating to the court's

adjudicatory function, only upon approval of the Supreme Court. A roll call vote is to be taken at such public hearing and the record shall state the vote of each judge or if they were absent or not voting. The effective date of the adoption, amendment, or repeal of any rule or regulation shall be established at the time of the public hearing, except that rules or regulations relating to the court's adjudicatory function shall become effective upon approval of the Supreme Court.

D. Publication and distribution of rules and regulations:

1. Copies of the rules and regulations in force and effect shall be published by the court and made available to the public, upon request, at a fee established by the court. Rules and regulations relating to the court's adjudicatory function shall be published in the Nebraska Advance Sheets upon approval of the Supreme Court, and copies of such rules and regulations shall be filed with the Clerk of the Supreme Court and Court of Appeals.
2. A current copy of the rules and regulations in force and effect and any updates to those rules and regulations, once adopted, shall be distributed, at no cost, by the court to the State Library and to each county law library or the largest public library in each county.

Section 48-164, R.R.S. 1998, sections 84-1408, 84-1409, 84-1410, 84-1413, 84-1414, R.R.S. 1999, and sections 48-156, 48-163, 84-1411, 84-1412, R.S. Supp., 2002.
Effective date July 28, 1999.

RULE 69

INSURANCE AND SELF INSURANCE

All employers subject to the Nebraska Workers' Compensation Act, except the State of Nebraska and any governmental agency created by the state, must either carry workers' compensation insurance, or, if eligible, may self-insure through a risk management pool, or, after application to and approval by the Nebraska Workers' Compensation Court, may self-insure their risk, or, in the case of an employer who is a lessor of one or more commercial vehicles leased to a self-insured motor carrier, may be a party to an effective agreement with the self-insured motor carrier under section 48-115.02. No employee may reject the provi-

sions of the Act. No employer, including religious or charitable institutions, and governmental subdivisions, may reject the provisions of the Act.

Sections 48-103, 48-112, 48-114, 48-115.02, 48-131, R.R.S. 1998, and sections 48-106, 48-145, 44-4304, R.S. Supp., 2002.
Effective date April 25, 2002.

RULE 70

SELF-INSURANCE
PURPOSE

A. The purpose of Rules 70 through 76 is to establish procedures and requirements for an employer seeking approval to self-insure its liability under the Nebraska Workers' Compensation Act, and for approval by the court to self insure.

B. No employer may self-insure its liability under the Act or make any representation that it self-insures its liability under the Act unless it has been approved by the court pursuant to these rules.

C. All financial information required by the court of an employer seeking approval to self-insure or an employer approved to self-insure shall be confidential.

D. An employer approved to self-insure may not delegate the ultimate responsibility for complying with the Act or rules of the court to any other party.

Section 48-145, R.S. Supp., 2002.
Effective date April 25, 2002.

RULE 71

SELF-INSURANCE
APPLICATION FOR APPROVAL

A. An employer seeking approval to self-insure its liability under the Nebraska Workers' Compensation Act shall submit a written request for an application

to the court. The written request for an application must be signed by a corporate officer and be on the employer's own letterhead. The employer requesting an application must:

1. have 100 employees in Nebraska or reasonably expect to have 100 employees in Nebraska within one (1) year of beginning operations in Nebraska;
2. have a minimum of five (5) years in business under the present organizational structure, and;
3. be a corporation or political subdivision.

B. All questions on the application for approval to self-insure must be fully and accurately answered. Such answers shall be given under oath by an authorized officer of the applicant. Each application for approval to self-insure must be accompanied by:

1. a nonrefundable fee which has been determined in accordance with section 48-145.04(1);
2. copies of the applicant's certified financial statements for the last five years;
3. a current payroll report broken down by job classification code plus payroll reports broken down by job classification code for the four previous consecutive years;
4. incurred loss history for the last five years;
5. evidence of authorization to transact business in Nebraska or status as a political subdivision, and;
6. any other information, including supporting documentation, as requested by the court.

Sections 48-145, 48-145.04, R.S. Supp. 2002.
Effective date April 25, 2002.

RULE 72

SELF-INSURANCE
REQUIREMENTS FOR APPROVAL

A. The following factors will be among those used in analyzing an application and determining whether an employer can be granted approval to self-insure:

1. standard financial ratio analysis and comparison to similar industry statistical data;
2. historical operating results;
3. evaluation of financial trends;
4. organizational structure and management background;
5. contingent liabilities;
6. pending litigation;
7. general and specific industry economic conditions;
8. number of employees;
9. current and historical loss experience, reserves, and modification factor;
10. safety program;
11. nature of business;
12. claim administration procedures, and;
13. proposed retention and limits for excess insurance.
14. claims record regarding delinquent payment of indemnity and medical expenses, as defined by section 48-125.

B. The court will approve employers to self insure who can provide:

1. satisfactory proof of financial strength and liquidity to meet all obligations under the Nebraska Workers' Compensation Act;
2. a fully executed parental guarantee if the employer is a subsidiary;
3. acceptable arrangements for claim administration and injury and payment reporting;
4. security in accordance with Rule 73;
5. excess insurance in accordance with Rule 74;

6. evidence of a safety committee and an effective written injury prevention program in accordance with section 48-443, and;

7. evidence of compliance with any other requirements under the Act and these rules.

C. After reviewing the application and all supporting documentation and other information the court will send written notice of approval, denial, or requirements for further consideration. If the court has additional requirements, the employer will have 30 days to comply. Upon receipt of a written request the court, at its discretion, may grant the employer additional time to comply. If all requirements are not met within the time prescribed, the application shall be considered withdrawn.

D. A certificate of approval to self-insure will be provided upon approval. The term of approval will be included on the certificate.

Sections 48-443, 48-444, 48-445, R.R.S. 1998, and sections 48-145, 48-446, R.S. Supp., 2002.
Effective date December 17, 2002.

RULE 73

SELF-INSURANCE SECURITY

A. Security Requirement. As a condition for approval to self-insure and continue to self-insure, the employer shall deposit an acceptable security to secure the payment of compensation liabilities under the Nebraska Workers' Compensation Act as they are incurred. Political subdivisions with either unlimited rate making authority or having taxing authority with a tax base of at least $2,500,000,000 and a general obligation bond rating from Standard & Poor or Moody's Investor Service of "A" or better may, at the discretion of the court, be excluded from this requirement.

B. Form of Security. Security shall be in the form of a surety bond or irrevocable workers' compensation trust agreement. Forms for bonds and trust agreements must be approved by the court.

C. Amount of Security.

1. The amount of security required, regardless of the method used for determining the amount, will be calculated using Nebraska specific

payroll, paid losses, or reserve. The reserve is the actual and present value of the determined and estimated future compensation payments under the Act.

2. One of two methods will be used by the court to calculate the amount of security required if the employer is able to provide paid loss totals for each of the last three complete calendar years. The formula method, as set out in Rule 73,D, will be used to determine the amount required unless the employer chooses to have the amount calculated based on an actuarial statement of reserve, as set out in Rule 73,F. If the employer is unable to provide paid loss totals for each of the last three complete calendar years, the court will determine the amount of security required based on actual and projected payroll by job classification code. The amount required may be periodically adjusted, at the court's discretion, until such time as the employer qualifies to have the amount of security determined by the formula or actuarial method.
3. The amount of security required will be determined when the application to self-insure is reviewed and at other times at the court's discretion.
4. Any change to the amount of security shall extend to all compensation liabilities of the employer as a self-insurer, including those liabilities already present, whether known or yet to be discovered.
5. Except in accordance with Rule 73,G the amount of security shall, in no case, be less than $500,000 or the reserve, whichever is greater.

D. Formula Method. The formula for determining the amount of security is the average of the employer's paid losses for the last three complete calendar years preceding the date the amount of security is determined, multiplied by 2.5. The product is increased by 40% or $500,000, whichever is greater. The result is the amount of the security required under the formula method.

E. Adjustments to the Formula Method. The amount of security required under the formula method may, at the discretion of the court, be adjusted based on the financial condition of the employer. For purposes of determining eligibility for such an adjustment self-insurers will be assigned to one of three classes. Assignment to a given class shall be in accordance with the criteria set forth in Rule 73,E,1 through Rule 73,E,3, based on the periodic review of financial and other records of the self-insured employer. The self-insurer and its parent, if applicable, must furnish annual audited financial statements to the court within a time frame established by the

court. To ascertain continued eligibility for a Class II or Class III designation, the court may periodically request financial statements and other information. Failure to comply with court requests for financial statements and other information will result in assignment to Class I.

1. Class I: Employers in Class I shall be required to deposit security in the full amount calculated according to the formula method as set out in Rule 73,D. Employers assigned to Class I are:
    a. Employers with a net worth of less than $100,000,000, excluding goodwill and restricted assets, or;
    b. Employers not showing a net profit in 4 out of the last 5 years, or:
    c. Employers not showing a positive operational cash flow in 4 out of the last 5 years regardless of net worth, or;
    d. Employers with a total reduction of net worth of 50% or more over the last 5 years, or;
    e. Employers with a reduction in net worth of 25% or more in the most recent year, or;
    f. Employers with a net worth between $100,000,000 and $250,000,000, excluding goodwill and restricted assets, and a net worth to asset ratio of less than 20% (i.e. net worth as a percent of assets) excluding goodwill and restricted assets from both net worth and assets, or;
    g. Employers terminating self-insurance for any reason, without regard to eligibility for another class.
2. Class II: Employers in Class II may, at the discretion of the court, be eligible for a 25% reduction in the amount of security calculated according to the formula method as set out in Rule 73,D. In no case shall the amount of security be less than $500,000 or the reserve, whichever is greater. Employers eligible for Class II are:
    a. Employers with a net worth between $100,000,000 and $250,000,000, excluding goodwill and restricted assets, and;
        i. Net profit in 4 out of the last 5 years, and;
        ii. Positive operational cash flow in 4 out of the last 5 years, and;
        iii. No reduction of net worth of 25% or more in the most recent year, and;

iv. No reduction of net worth of 50% or more over the last five years, and;

v. A net worth to asset ratio of between 20% and 66.67% (i.e. net worth as a percent of assets) excluding goodwill and restricted assets from both net worth and assets;

OR

b. Employers with a net worth of $250,000,000 or more excluding goodwill and restricted assets, and;

i. Net profit in 4 out of the last 5 years, and;

ii. Positive operational cash flow in 4 out of the last 5 years, and;

iii. No reduction of net worth of 25% or more in the most recent year, and;

iv. No reduction of net worth of 50% or more over the last five years, and;

v. A net worth to asset ratio of less than 20% (i.e. net worth as a percent of assets) excluding goodwill and restricted assets from both net worth and assets.

3. Class III: Employers in Class III may, at the discretion of the court, be eligible for a 50% reduction in the amount of security calculated according to the formula method as set out in Rule 73,D. In no case shall the amount of security be less than $500,000 or the reserve, whichever is greater. Employers eligible for Class III are:

a. Employers with a net worth between $100,000,000 and $250,000,000, excluding goodwill and restricted assets, and;

i. Net profit in 4 out of the last 5 years, and;

ii. Positive operational cash flow in 4 out of the last 5 years, and;

iii. No reduction of net worth of 25% or more in the most recent year and;

iv. No reduction of net worth of 50% or more over the last five years, and;

v. A net worth to asset ratio of 66.67% or more (i.e. net worth as a percentage of assets) excluding goodwill and restricted assets from both net worth and assets.

OR

b. Employers with a net worth of $250,000,000 or more excluding goodwill and restricted assets, and;

i. Net profit in 4 out of the last 5 years, and;

ii. Positive operational cash flow in 4 out of the last 5 years, and;

iii. No reduction of net worth of 25% or more in the most recent year, and;

iv. No reduction of net worth of 50% or more over the last five years, and;

v. A net worth to asset ratio of 20% or more (i.e. net worth as a percent of assets) excluding goodwill and restricted assets from both net worth and assets.

F. Actuarial Method. As an alternative to the formula method of determining the amount of security required, the court will calculate the amount required based on an actuarial estimate of compensation liabilities. In no case shall the amount of security be less than $500,000.

1. A qualified independent actuary who is a member of the American Academy of Actuaries or Casualty Actuarial Society must perform an analysis of the self-insurer's workers' compensation liabilities and provide a certified statement of the reserve. The opinion must include a statement that there is no impediment to the actuary's ability to provide an unbiased and independent opinion as to the adequacy of the reserve. The report must also include a synopsis of the nature of the actuary's approach.
2. The self-insurer is responsible for any cost associated with obtaining the statement.
3. The amount of security required is equal to 66.67% of the actual reserve amount, increased by 40% or $500,000 whichever is greater.
4. An actuarial statement of the reserve must be provided with the application to self-insure. Failure to provide an actuarial statement shall result in the security amount being calculated using the formula method as set out in Rules 73,D and 73,E.

G. Reduction or Release of Security after Termination of Self-Insurance. An employer whose approval to self-insure has been terminated for at least two years may submit a written request to the court to reduce the amount of security. At its discretion, with satisfactory proof of the actual amount of outstanding compensation liabilities, the court may approve a reduction in

the amount of security required. Unless an employer provides the court with satisfactory proof of the transfer of all outstanding compensation liabilities, no security will be released for at least two years after approval to self-insure terminates.

Section 48-145, R.S. Supp., 2002.
Effective date December 17, 2002.

RULE 74

SELF-INSURANCE
EXCESS INSURANCE

Specific excess workers' compensation insurance shall be required of each approved self-insurer. Aggregate excess insurance may be required as a condition of approval to self-insure, at the discretion of the court.

A. Political subdivisions with either unlimited rate making authority or having taxing authority with a tax base of at least $2,500,000,000 and with a general obligation bond rating from Standard & Poor or Moody's Investor Service of "A" or better may, at the discretion of the court, be excluded from this requirement.

B. The specified upper limit of coverage must be "statutory" and the retention amounts must be approved by the court.

C. Each excess workers' compensation policy must be issued by a corporation, association, or organization authorized and licensed by the Nebraska Department of Insurance to transact the business of workers' compensation insurance in this state.

D. All excess workers' compensation policy forms and endorsements must be filed with and approved by the Nebraska Department of Insurance. The Nebraska Amendatory Endorsement is required for all excess workers' compensation policies.

E. An exact copy of each excess workers' compensation policy must be filed with the court, in its entirety, including any endorsements, amendments, and schedules.

Section 48-145, R.S. Supp., 2002.
Effective date December 17, 2002.

RULE 75

SELF-INSURANCE
REPORTING REQUIREMENTS

A. The court shall be notified promptly of contemplated mergers, consolidations, acquisitions, divesting or spinning off of current operations, and other major organizational changes.

B. The court shall be notified promptly when there is any change in third party administrator, address, court contact, Nebraska Registered Agent, security, or other information in the application.

C. The court shall be notified within ten days by certified mail of any bankruptcy filing by the self-insurer or its parent, or any subsidiary of the self-insurer or its parent.

D. The self-insurer will furnish additional reports or other information the court may require on an annual or as needed basis.

E. The court may conduct periodic audits and special examinations of the self-insurer's payroll and other workers' compensation records, or the records of a third party administrator or other agent acting on behalf of the self-insurer, to ensure compliance with self-insurance requirements and other obligations under the Nebraska Workers' Compensation Act.

Section 48-145, R.S. Supp., 2002.
Effective date April 25, 2002.

RULE 76

SELF-INSURANCE
RENEWAL, TERMINATION

A. An employer desiring to renew approval to self-insure its liability under the Nebraska Workers' Compensation Act must submit an application to the court thirty days prior to the expiration date shown on the current certificate. Upon receipt of a written request the court, at its discretion, may grant the employer additional time to comply. If the application is not submitted within the time prescribed, approval to self-insure will expire on the date shown on the current certificate or other date specified by the court.

B. All questions on the application for renewal of approval to self-insure must be fully and accurately answered. Such answers shall be given under oath by an authorized officer of the applicant. Each application must be accompanied by:

1. a nonrefundable fee which has been determined in accordance with section 48-145.04(1);
2. a copy of the applicant's most recent certified financial statement, and;
3. any other information, including supporting documentation, as requested by the court.

C. Upon receipt of the application and all fees, supporting documentation, and other information, approval to self-insure will be extended until the employer is provided a certificate evidencing renewal of approval to self-insure or until the employer is notified of nonrenewal and the date approval to self-insure will expire.

D. The application, supporting documentation, and other information will be analyzed and continued approval to self-insure will be in accordance with Rules 72,A and 72,B.

E. After reviewing the application and all supporting documentation and other information, the court will send written notice of renewal or nonrenewal of approval, or requirements for further consideration. If the court has additional requirements, the employer will have 30 days to comply. Upon receipt of a written request the court, at its discretion, may grant the employer additional time to comply. If all requirements are not met within the time prescribed, the application for renewal shall be considered denied and approval to self-insure will expire on the date specified by the court.

F. An applicant denied renewal of approval to self-insure may not reapply for one year after receipt of notice of denial.

G. An employer may voluntarily terminate approval to self-insure prior to the expiration date shown on the current certificate by providing the court with written notice of the reason for termination, the date and time of the intended termination, the name of the insurer assuming the risk after termination, and the policy number and effective date of the workers' compensation insurance policy.

Sections 48-145, 48-145.04, R.S. Supp., 2002.
Effective date April 25, 2002.

* * * * *

ADDENDA

ADDENDUM 1

PRESENT VALUE TABLE
NEBRASKA WORKERS' COMPENSATION COURT

Present value of annuity certain of $1.00 per week. Interest at five percent per annum with annual rests. Payment at end of week 365.2425 days to a year.

TO USE TABLES:
Find present value of $1.00 for number of weeks to be commuted; multiply the value so found by the weekly compensation rate.

EXAMPLE: Weeks to be commuted, 215; weekly compensation rate, $62.00; present value of $1.00 for 215 weeks is $194.2141; multiplying $194.2141 by $62.00 produces the commuted value of $12,041.27.

EXAMPLE WHERE WEEKLY RATE CHANGES: Weeks to be commuted, 1,100; first 175 weeks at $62.00; following 925 weeks at $47.00 (1,100 weeks at $47.00 per week plus 175 weeks at $15.00 per week running concurrently, beginning with the first week, produces the same result.) Present value of $1.00 for 1,100 weeks is $679.6809; multiplying $679.6809 by $47.00 produces $31,945.00. Present value of $1.00 for 175 weeks is $161.0426; multiplying $161.0426 by $15 produces $2,415.64. Adding $31,945.00 to $2,415.64 makes a total of $34,360.64, being the present worth of 1,100 weeks at the rates stated.

Weeks	Present Value	Weeks	Present Value	Weeks	Present Value	Weeks	Present Value
1	$0.9990	61	$59.2238	121	$114.1969	181	$166.0997
2	$1.9971	62	$60.1662	122	$115.0866	182	$166.9398
3	$2.9943	63	$61.1076	123	$115.9754	183	$167.7790
4	$3.9904	64	$62.0482	124	$116.8635	184	$168.6174
5	$4.9857	65	$62.9878	125	$117.7506	185	$169.4550
6	$5.9799	66	$63.9265	126	$118.6369	186	$170.2918
7	$6.9732	67	$64.8644	127	$119.5224	187	$171.1278
8	$7.9656	68	$65.8013	128	$120.4070	188	$171.9631
9	$8.9570	69	$66.7374	129	$121.2908	189	$172.7975
10	$9.9475	70	$67.6725	130	$122.1737	190	$173.6311
11	$10.9370	71	$68.6068	131	$123.0558	191	$174.4639
12	$11.9256	72	$69.5401	132	$123.9370	192	$175.2959
13	$12.9132	73	$70.4726	133	$124.8174	193	$176.1271
14	$13.8999	74	$71.4042	134	$125.6970	194	$176.9576
15	$14.8856	75	$72.3349	135	$126.5757	195	$177.7872
16	$15.8704	76	$73.2647	136	$127.4535	196	$178.6160
17	$16.8543	77	$74.1936	137	$128.3306	197	$179.4441
18	$17.8372	78	$75.1216	138	$129.2067	198	$180.2713
19	$18.8191	79	$76.0487	139	$130.0821	199	$181.0978
20	$19.8002	80	$76.9749	140	$130.9566	200	$181.9235
21	$20.7803	81	$77.9003	141	$131.8303	201	$182.7483
22	$21.7594	82	$78.8248	142	$132.7031	202	$183.5724
23	$22.7376	83	$79.7483	143	$133.5751	203	$184.3957
24	$23.7149	84	$80.6710	144	$134.4463	204	$185.2182
25	$24.6912	85	$81.5928	145	$135.3166	205	$186.0400
26	$25.6666	86	$82.5138	146	$136.1861	206	$186.8609
27	$26.6411	87	$83.4338	147	$137.0548	207	$187.6811
28	$27.6146	88	$84.3530	148	$137.9226	208	$188.5004
29	$28.5872	89	$85.2713	149	$138.7896	209	$189.3190
30	$29.5589	90	$86.1887	150	$139.6558	210	$190.1368
31	$30.5297	91	$87.1052	151	$140.5211	211	$190.9538
32	$31.4995	92	$88.0209	152	$141.3856	212	$191.7701
33	$32.4684	93	$88.9356	153	$142.2493	213	$192.5855
34	$33.4363	94	$89.8495	154	$143.1122	214	$193.4002
35	$34.4034	95	$90.7626	155	$143.9742	215	$194.2141
36	$35.3695	96	$91.6747	156	$144.8354	216	$195.0272
37	$36.3347	97	$92.5860	157	$145.6958	217	$195.8395
38	$37.2989	98	$93.4964	158	$146.5554	218	$196.6511
39	$38.2622	99	$94.4059	159	$147.4141	219	$197.4618
40	$39.2247	100	$95.3146	160	$148.2720	220	$198.2718
41	$40.1861	101	$96.2224	161	$149.1291	221	$199.0811
42	$41.1467	102	$97.1293	162	$149.9854	222	$199.8895
43	$42.1064	103	$98.0354	163	$150.8408	223	$200.6972
44	$43.0651	104	$98.9406	164	$151.6955	224	$201.5041
45	$44.0229	105	$99.8449	165	$152.5493	225	$202.3102
46	$44.9798	106	$100.7483	166	$153.4023	226	$203.1156
47	$45.9358	107	$101.6509	167	$154.2545	227	$203.9202
48	$46.8909	108	$102.5527	168	$155.1058	228	$204.7240
49	$47.8450	109	$103.4535	169	$155.9564	229	$205.5271
50	$48.7982	110	$104.3535	170	$156.8061	230	$206.3293
51	$49.7506	111	$105.2527	171	$157.6551	231	$207.1309
52	$50.7020	112	$106.1509	172	$158.5032	232	$207.9316
53	$51.6525	113	$107.0484	173	$159.3505	233	$208.7316
54	$52.6021	114	$107.9449	174	$160.1970	234	$209.5308
55	$53.5508	115	$108.8406	175	$161.0426	235	$210.3292
56	$54.4985	116	$109.7355	176	$161.8875	236	$211.1269
57	$55.4454	117	$110.6295	177	$162.7316	237	$211.9238
58	$56.3914	118	$111.5226	178	$163.5748	238	$212.7200
59	$57.3364	119	$112.4149	179	$164.4173	239	$213.5154
60	$58.2806	120	$113.3063	180	$165.2589	240	$214.3100

Weeks	Present Value	Weeks	Present Value	Weeks	Present Value	Weeks	Present Value
241	$215.1039	301	$261.3713	361	$305.0547	421	$346.2985
242	$215.8970	302	$262.1201	362	$305.7617	422	$346.9660
243	$216.6894	303	$262.8682	363	$306.4680	423	$347.6329
244	$217.4810	304	$263.6156	364	$307.1737	424	$348.2991
245	$218.2718	305	$264.3623	365	$307.8786	425	$348.9647
246	$219.0619	306	$265.1082	366	$308.5829	426	$349.6297
247	$219.8512	307	$265.8535	367	$309.2866	427	$350.2940
248	$220.6398	308	$266.5980	368	$309.9895	428	$350.9577
249	$221.4276	309	$267.3418	369	$310.6918	429	$351.6207
250	$222.2147	310	$268.0849	370	$311.3934	430	$352.2831
251	$223.0010	311	$268.8273	371	$312.0943	431	$352.9449
252	$223.7865	312	$269.5690	372	$312.7946	432	$353.6061
253	$224.5713	313	$270.3099	373	$313.4942	433	$354.2666
254	$225.3554	314	$271.0502	374	$314.1931	434	$354.9265
255	$226.1387	315	$271.7898	375	$314.8913	435	$355.5857
256	$226.9212	316	$272.5286	376	$315.5889	436	$356.2444
257	$227.7030	317	$273.2667	377	$316.2858	437	$356.9023
258	$228.4841	318	$274.0042	378	$316.9821	438	$357.5597
259	$229.2644	319	$274.7409	379	$317.6776	439	$358.2164
260	$230.0439	320	$275.4769	380	$318.3726	440	$358.8725
261	$230.8227	321	$276.2122	381	$319.0668	441	$359.5280
262	$231.6008	322	$276.9468	382	$319.7604	442	$360.1829
263	$232.3781	323	$277.6808	383	$320.4533	443	$360.8371
264	$233.1547	324	$278.4140	384	$321.1456	444	$361.4907
265	$233.9305	325	$279.1465	385	$321.8372	445	$362.1437
266	$234.7056	326	$279.8783	386	$322.5281	446	$362.7960
267	$235.4800	327	$280.6094	387	$323.2184	447	$363.4477
268	$236.2536	328	$281.3398	388	$323.9080	448	$364.0988
269	$237.0264	329	$282.0695	389	$324.5969	449	$364.7493
270	$237.7986	330	$282.7985	390	$352.2852	450	$365.3991
271	$238.5699	331	$283.5268	391	$325.9728	451	$366.0484
272	$239.3406	332	$284.2544	392	$326.6598	452	$366.6970
273	$240.1105	333	$284.9813	393	$327.3461	453	$367.3450
274	$240.8797	334	$285.7075	394	$328.0318	454	$367.9923
275	$241.6481	335	$286.4330	395	$328.7168	455	$368.6391
276	$242.4158	336	$287.1579	396	$329.4011	456	$369.2852
277	$243.1828	337	$287.8820	397	$330.0848	457	$369.9307
278	$243.9490	338	$288.6054	398	$330.7679	458	$370.5756
279	$244.7145	339	$289.3282	399	$331.4502	459	$371.2199
280	$245.4793	340	$290.0502	400	$332.1320	460	$371.8635
281	$246.2433	341	$290.7716	401	$332.8130	461	$372.5066
282	$247.0066	342	$291.4923	402	$333.4935	462	$373.1490
283	$247.7692	343	$292.2122	403	$334.1732	463	$373.7908
284	$248.5310	344	$292.9315	404	$334.8524	464	$374.4320
285	$249.2921	345	$293.6501	405	$335.5308	465	$375.0726
286	$250.0525	346	$294.3681	406	$336.2087	466	$375.7125
287	$250.8122	347	$295.0853	407	$336.8858	467	$376.3519
288	$251.5711	348	$295.8018	408	$337.5624	468	$376.9906
289	$252.3293	349	$296.5177	409	$338.2382	469	$377.6288
290	$253.0868	350	$297.2329	410	$338.9135	470	$378.2663
291	$253.8435	351	$297.9473	141	$339.5881	471	$378.9032
292	$254.5995	352	$298.6612	412	$340.2620	472	$379.5395
293	$255.3548	353	$299.3743	413	$340.9353	473	$380.1752
294	$256.1094	354	$300.0867	414	$341.6079	474	$380.8103
295	$256.8633	355	$300.7985	415	$342.2799	475	$381.4447
296	$257.6164	356	$301.5095	416	$342.9513	476	$382.0786
297	$258.3688	357	$302.2199	417	$343.6220	477	$382.7119
298	$259.1205	358	$302.9296	418	$344.2921	478	$383.3445
299	$259.8715	359	$303.6387	419	$344.9615	479	$383.9766
300	$260.6217	360	$304.3470	420	$345.6303	480	$384.6080

Weeks	Present Value	Weeks	Present Value	Weeks	Present Value	Weeks	Present Value
481	$385.2388	541	$422.0045	601	$456.7168	661	$489.4905
482	$385.8691	542	$422.5995	602	$457.2786	662	$490.0209
483	$386.4987	543	$423.1940	603	$457.8398	663	$490.5508
484	$387.1277	544	$423.7879	604	$458.4006	664	$491.0802
485	$387.7562	545	$424.3812	605	$458.9608	665	$491.6091
486	$388.3840	546	$424.9740	606	$459.5204	666	$492.1375
487	$389.0112	547	$425.5661	607	$460.0795	667	$492.6654
488	$389.6378	548	$426.1578	608	$460.6381	668	$493.1928
489	$390.2639	549	$426.7488	609	$461.1962	669	$493.7197
490	$390.8893	550	$427.3393	610	$461.7537	670	$494.2461
491	$391.5141	551	$427.9293	611	$462.3107	671	$494.7720
492	$392.1383	552	$428.5186	612	$462.8671	672	$495.2973
493	$392.7620	553	$429.1074	613	$463.4230	673	$495.8222
494	$393.3850	554	$429.6957	614	$463.9784	674	$496.3466
495	$394.0074	555	$430.2833	615	$464.5333	675	$496.8704
496	$394.6293	556	$430.8704	616	$465.0876	676	$497.3938
497	$395.2505	557	$431.4570	617	$465.6414	677	$497.9167
498	$395.8712	558	$432.0430	618	$466.1947	678	$498.4390
499	$396.4912	559	$432.6284	619	$466.7474	679	$498.9609
500	$397.1107	560	$433.2133	620	$467.2996	680	$499.4822
501	$397.7295	561	$433.7976	621	$467.8513	681	$500.0031
502	$398.3478	562	$434.3813	622	$468.4024	682	$500.5235
503	$398.9655	563	$434.9645	623	$468.9530	683	$501.0433
504	$399.5826	564	$435.5471	624	$469.5031	684	$501.5627
505	$400.1991	565	$436.1292	625	$470.0527	685	$502.0816
506	$400.8150	566	$436.7107	626	$470.6017	686	$502.6000
507	$401.4303	567	$437.2917	627	$471.1502	687	$503.1178
508	$402.0451	568	$437.8721	628	$471.6982	688	$503.6352
509	$402.6592	569	$438.4519	629	$472.2457	689	$504.1521
510	$403.2728	570	$439.0312	630	$472.7926	690	$504.6685
511	$403.8857	571	$439.6100	631	$473.3390	691	$505.1844
512	$404.4981	572	$440.1881	632	$473.8849	692	$505.6998
513	$405.1099	573	$440.7658	633	$474.4303	693	$506.2147
514	$405.7211	574	$441.3428	634	$474.9751	694	$506.7291
515	$406.3318	575	$441.9194	635	$475.5195	695	$507.2431
516	$406.9418	576	$442.4953	636	$476.0633	696	$507.7565
517	$407.5513	577	$443.0708	637	$476.6066	697	$508.2694
518	$408.1601	578	$443.6456	638	$477.1493	698	$508.7819
519	$408.7684	579	$444.2199	639	$477.6916	699	$509.2938
520	$409.3761	580	$444.7937	640	$478.2333	700	$509.8053
521	$409.9833	581	$445.3669	641	$478.7745	701	$510.3163
522	$410.5898	582	$445.9396	642	$479.3152	702	$510.8268
523	$411.1958	583	$446.5117	643	$479.8553	703	$511.3368
524	$411.8011	584	$447.0833	644	$480.3950	704	$511.8463
525	$412.4060	585	$447.6543	645	$480.9341	705	$512.3553
526	$413.0102	586	$448.2248	646	$481.4728	706	$512.8639
527	$413.6138	587	$448.7947	647	$482.0109	707	$513.3719
528	$414.2169	588	$449.3641	648	$482.5485	708	$513.8795
529	$414.8194	589	$449.9330	649	$483.0855	709	$514.3866
530	$415.4213	590	$450.5013	650	$483.6221	710	$514.8932
531	$416.0226	591	$451.0690	651	$484.1581	711	$515.3993
532	$416.6234	592	$451.6362	652	$484.6937	712	$515.9049
533	$417.2236	593	$452.2029	653	$485.2287	713	$516.4100
534	$417.8232	594	$452.7690	654	$485.7632	714	$516.9147
535	$418.4222	595	$453.3346	655	$486.2972	715	$517.4189
536	$419.0207	596	$453.8997	656	$486.8307	716	$517.9226
537	$419.6186	597	$454.4642	657	$487.3637	717	$518.4258
538	$420.2159	598	$455.0281	658	$487.8961	718	$518.9285
539	$420.8127	599	$455.5915	659	$488.4281	719	$519.4307
540	$421.4089	600	$456.1544	660	$488.9595	720	$519.9325

Weeks	Present Value	Weeks	Present Value	Weeks	Present Value	Weeks	Present Value
721	$520.4338	781	$549.6490	841	$577.2326	901	$603.2756
722	$520.9346	782	$550.1218	842	$577.6790	902	$603.6971
723	$521.4349	783	$550.5942	843	$578.1250	903	$604.1182
724	$521.9348	784	$551.0661	844	$578.5706	904	$604.5389
725	$522.4341	785	$551.5376	845	$579.0157	905	$604.9592
726	$522.9330	786	$552.0086	846	$579.4604	906	$605.3791
727	$523.4314	787	$552.4792	847	$579.9047	907	$605.7986
728	$523.9294	788	$552.9493	848	$580.3486	908	$606.2177
729	$524.4268	789	$553.4190	849	$580.7920	909	$606.6363
730	$524.9238	790	$553.8883	850	$581.2351	910	$607.0546
731	$525.4203	791	$554.3570	851	$581.6777	911	$607.4725
732	$525.9164	792	$554.8254	852	$582.1198	912	$607.8900
733	$526.4119	793	$555.2932	853	$582.5616	913	$608.3070
734	$526.9070	794	$555.7607	854	$583.0029	914	$608.7237
735	$527.4016	795	$556.2277	855	$583.4438	915	$609.1400
736	$527.8957	796	$556.6942	856	$583.8843	916	$609.5559
737	$528.3894	797	$557.1603	857	$584.3244	917	$609.9714
738	$528.8826	798	$557.6259	858	$584.7640	918	$610.3865
739	$529.3753	799	$558.0911	859	$585.2032	919	$610.8012
740	$529.8676	800	$558.5559	860	$585.6420	920	$611.2154
741	$530.3593	801	$559.0202	861	$586.0804	921	$611.6293
742	$530.8506	802	$559.4841	862	$586.5184	922	$612.0428
743	$531.3415	803	$559.9475	863	$586.9559	923	$612.4559
744	$531.8318	804	$560.4105	864	$587.3930	924	$612.8687
745	$532.3217	805	$560.8730	865	$587.8297	925	$613.2810
746	$532.8111	806	$561.3351	866	$588.2660	926	$613.6929
747	$533.3001	807	$561.7967	867	$588.7019	927	$614.1044
748	$533.7886	808	$562.2579	868	$589.1373	928	$614.5155
749	$534.2766	809	$562.7187	869	$589.5724	929	$614.9263
750	$534.7642	810	$563.1790	870	$590.0070	930	$615.3366
751	$535.2512	811	$563.6389	871	$590.4412	931	$615.7466
752	$535.7379	812	$564.0984	872	$590.8750	932	$616.1561
753	$536.2240	813	$564.5574	873	$591.3083	933	$616.5653
754	$536.7097	814	$565.0159	874	$591.7413	934	$616.9741
755	$537.1949	815	$565.4740	875	$592.1738	935	$617.3824
756	$537.6797	816	$565.9317	876	$592.6059	936	$617.7904
757	$538.1640	817	$566.3890	877	$593.0376	937	$618.1980
758	$538.6478	818	$566.8458	878	$593.4689	938	$618.6052
759	$539.1312	819	$567.3022	879	$593.8998	939	$619.0121
760	$539.6141	820	$567.7581	880	$594.3303	940	$619.4185
761	$540.0965	821	$568.2136	881	$594.7604	941	$619.8245
762	$540.5785	822	$568.6687	882	$595.1900	942	$620.2302
763	$541.0600	823	$569.1233	883	$595.6193	943	$620.6355
764	$541.5411	824	$569.5775	884	$596.0481	944	$621.0403
765	$542.0217	825	$570.0312	885	$596.4765	945	$621.4448
766	$542.5018	826	$570.4846	886	$596.9045	946	$621.8489
767	$542.9815	827	$570.9374	887	$597.3321	947	$622.2526
768	$543.4607	828	$571.3899	888	$597.7593	948	$622.6560
769	$543.9395	829	$517.8419	889	$598.1861	949	$623.0589
770	$544.4178	830	$572.2935	890	$598.6124	950	$623.4615
771	$544.8956	831	$572.7447	891	$599.0384	951	$623.8636
772	$545.3730	832	$573.1954	892	$599.4639	952	$624.2654
773	$545.8499	833	$573.6457	893	$599.8891	953	$624.6668
774	$546.3264	834	$574.0956	894	$600.3138	954	$625.0679
775	$546.8024	835	$574.5450	895	$600.7382	955	$625.4685
776	$547.2780	836	$574.9940	896	$601.1621	956	$625.8687
777	$547.7531	837	$575.4426	897	$601.5856	957	$626.2686
778	$548.2278	838	$575.8907	898	$602.0087	958	$626.6681
779	$548.7020	839	$576.3384	899	$602.4314	959	$627.0672
780	$549.1757	840	$576.7857	900	$602.8537	960	$627.4659

Weeks	Present Value	Weeks	Present Value	Weeks	Present Value	Weeks	Present Value
961	$627.8642	986	$637.6997	1,110	$683.1494	1,700	$838.7346
962	$628.2622	987	$638.0882	1,120	$686.5849	1,800	$857.4418
963	$628.6598	988	$638.4764	1,130	$689.9876	1,900	$874.4404
964	$629.0570	989	$638.8642	1,140	$693.3579	2,000	$889.8863
965	$629.4538	990	$639.2516	1,150	$696.6961	2,200	$916.6747
966	$629.8502	991	$639.6387	1,160	$700.0024	2,400	$938.7930
967	$630.2463	992	$640.0254	1,170	$703.2772	2,600	$957.0555
968	$630.6420	993	$640.4117	1,180	$706.5208	2,800	$972.1342
969	$631.0373	994	$640.7976	1,190	$709.7335	3,000	$984.5842
970	$631.4322	995	$641.1832	1,200	$712.9156	3,300	$999.3106
971	$631.8267	996	$641.5684	1,210	$716.0673	3,600	$1,010.3592
972	$632.2209	997	$641.9533	1,220	$719.1890	4,000	$1,020.9229
973	$632.6147	998	$642.3377	1,230	$722.2809	4,500	$1,029.5334
974	$633.0081	999	$642.7218	1,240	$725.3434	5,000	$1,034.8672
975	$633.4011	1,000	$643.1056	1,250	$728.3766	6,000	$1,040.2181
976	$633.7938	1,010	$646.9227	1,260	$731.3810	7,000	$1,042.2715
977	$634.1860	1,020	$650.7035	1,270	$734.3567	8,000	$1,043.0594
978	$634.5779	1,030	$654.4483	1,280	$737.3040	10,000	$1,043.4778
979	$634.9695	1,040	$658.1573	1,290	$740.2233		
980	$635.3606	1,050	$661.8311	1,300	$743.1147		
981	$635.7514	1,060	$665.4697	1,350	$757.1636		
982	$636.1418	1,070	$669.0737	1,400	$770.5555		
983	$636.5318	1,080	$672.6434	1,450	$783.3212		
984	$636.9215	1,090	$676.1790	1,500	$795.4900		
985	$637.3108	1,100	$679.6809	1,600	$818.1470		

ADDENDUM 2

U.S. LIFE TABLE: 1999

Expectancy Expressed in Years

NEBRASKA WORKERS' COMPENSATION COURT

AGE	EXPECTANCY	AGE	EXPECTANCY
10	67.4	48	31.6
11	66.4	49	30.7
12	65.5	50	29.8
13	64.5	51	29.0
14	63.5	52	28.1
15	62.5	53	27.2
16	61.5	54	26.4
17	60.6	55	25.5
18	59.6	56	24.7
19	58.7	57	23.9
20	57.7	58	23.1
21	56.8	59	22.3
22	55.8	60	21.5
23	54.9	61	20.7
24	53.9	62	20.0
25	53.0	63	19.2
26	52.0	64	18.5
27	51.1	65	17.7
28	50.1	66	17.0
29	49.2	67	16.3
30	48.2	68	15.6
31	47.3	69	15.0
32	46.3	70	14.3
33	45.4	71	13.7
34	44.4	72	13.0
35	43.5	73	12.4
36	42.6	74	11.8
37	41.6	75	11.2
38	40.7	76	10.7
39	39.8	77	10.1
40	38.8	78	9.6
41	37.9	79	9.0
42	37.0	80	8.5
43	36.1	81	8.0
44	35.2	82	7.5
45	34.3	83	7.1
46	33.4	84	6.7
47	32.5	85	6.3

ADDENDUM 3

NEBRASKA WORKERS' COMPENSATION COURT EXPECTANCY FACTORS FOR WIDOWS

Repealed effective January 1, 1997.

ADDENDUM 4

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ADDENDUM 5

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ADDENDUM 6

NEBRASKA WORKERS' COMPENSATION COURT MINIMUM STANDARDS FOR SELF INSURERS

Repealed effective April 25, 2002.